


ON LOAN



COUNTY COUNCIL OF DEVON

THE
HEALTH
OF
DEVON
IN
1970 and 1971

THE BIENNIAL REPORT
of the COUNTY MEDICAL OFFICER and
PRINCIPAL SCHOOL MEDICAL OFFICER



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COUNTY COUNCIL OF DEVON

BIENNIAL REPORT

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

FOR THE YEARS

1970 and 1971

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DEVON HEALTH COMMITTEE

as at 31st December, 1971

Health Committee

Chairman: †Rev. J. W. Timms.

Vice-Chairman: Mrs. M. Owen.

Chairman of the Council (ex officio).

Vice-Chairman of the Council (ex officio).

Chairman of the Finance Committee (ex officio).

Mr. Angel	Mrs. Hindson	Mr. Ridd-Jones
Mrs Broad	Mr. Hughes	Lt. Col. Roberts
Mr. Daymond	Mrs. Langley	Mr. Scoble
Mrs. Gibbens	§Mrs. Perkin	Mr. Staddon
Mrs. Hampson	Mr. Peters	Mr. Thomas
Mr. Heggadon	Mrs. Ratcliffe	
Rev. F. J. H. Hendy	Rev. G. F. Rickard	

Nominated by the following bodies:

Community Council of Devon—Dr. A. Robinson Thomas

Devon Branch, British Red Cross Society—Miss D. Dance Jones

Devon Branch, St. John Ambulance Brigade—*Major T. W. Gracey

Devon and Exeter Local Dental Association—Mr. G. Pendlebury

Devon and Exeter Local Medical Committee—Dr. R. M. S. McConaghey,
O.B.E., Dr. G. C. C. McVicker

Devon and Exeter Pharmaceutical Committee—Mr. H. Jarvis Graves

Executive Council for Devon, Exeter and Torbay—Mr. A. D. J. Harvey

Women's Royal Voluntary Service—Mrs. R. Croft, M.B.E.

* Chairman of Ambulance, † General Purposes and § Nursing sub-committees.

INTRODUCTION

HEALTH DEPARTMENT,
COUNTY HALL,
EXETER.

August 1972

To: The Chairman, Aldermen and Members
of the Devon County Council.

Mr. Chairman, My Lord,
Ladies and Gentlemen,

I have the pleasure of presenting my statutory reports for 1970 and 1971. The reports contain details of the services provided by the health committee for the prevention of illness, promotion of health and the care and after-care of persons in the community, and by the education committee in respect of the school health service.

The most significant feature of the developments of the county council's health services during the past seven or eight years has been increased co-operation with the other branches of the National Health Service and especially with family doctors. This has been shown in the increased "attachment" of nursing staff to family doctors and in the continuing growth of health centres, thirty of which are now in operation.

In a recent survey carried out by the Exeter University Institute of Biometry and Community Medicine over five hundred patients were questioned about their attitudes to their local health centre. It is not without significance that only three of the patients expressed positive dissatisfaction with the health centre.

This extraordinarily low level of adverse criticism should encourage the members of the county council to continue to favour health centre projects.

I wish to thank members of the health Committee for their continued and unwavering support which has enabled so much of value to be achieved, and to pay tribute to the devotion, loyalty and energy of the health department staff.

J. LYONS

County Medical Officer and
Principal School Medical Officer.

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1971

County Medical Officer and Principal School Medical Officer	J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H., F.F.C.M.
--	-----	-----	--

Deputy County Medical Officer and Deputy Principal School Medical Officer	A. D. Lepine, M.R.C.S., L.R.C.P., D.P.H., M.F.C.M.
---	-----	-----	-----	---

Senior Medical Officer for Child Health	D. O. McKnight, M.B., B.S., D.C.H., D.P.H., M.F.C.M.
--	-----	-----	-----	---

Senior Medical Officer	J. A. Theobald, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., M.F.C.M.
------------------------	-----	-----	---

Director of Nursing Services	...	Miss A. Varley, S.R.N., S.C.M., H.V.C., Q.N.
------------------------------	-----	---

Health Education Officer	Mrs. D. E. Tait, D.H.ED., S.R.N., S.C.M., Q.N.
--------------------------	-----	-----	---

County Health Inspector	M. S. Powling, F.A.P.H.I., F.I.P.H.E.
-------------------------	-----	-----	---------------------------------------

County Ambulance Officer	R. P. Selley, V.R.D., D.P.A., F.H.A., F.I.A.O.
--------------------------	-----	-----	---

Chief Chiropody Officer	W. Beedle, M.Ch.S., R.M.A., S.R.Ch.
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Administrative Officers:

Chief Administrative Officer	...	J. Cooke
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Chief Clerk	H. T. Baldwyn
-------------	-----	-----	-----	---------------

Child Health and Nursing Section	K. G. Baker
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General Section	P. M. Milton
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MEDICAL OFFICERS

L. G. Anderson, M.D., Ch.B., D.P.H.	} “mixed” appointments
M. E. Budding, B.Sc., M.B., Ch.B., D.P.H.	
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P.	
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.	
A. H. Halstead, M.B., B.S., D.P.H.	
R. C. MacLeod, M.D., D.P.H., D.T.M. & H.	
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.	
E. Williams, M.R.C.S., L.R.C.P., D.P.H.	
J. Allott, M.B., Ch.B., D.P.H.	
R. M. Beasley, M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (part-time)	
E. A. Chalk, B.A., B.M., B.Ch. (part-time)	
M. J. Dunn, M.B., Ch.B.	
C. L. Grant, M.B., Ch.B., M.D., F.R.C.P. (part-time)	
F. H. Lamb, Surgeon-Captain, M.R.C.S., L.R.C.P. (part-time)	
F. C. R. Mackenzie, M.B., B.S. (part-time)	
J. M. Mallett, M.B., Ch.B., D.P.H. (part-time)	
J. M. Shields, M.B., B.S., M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (part-time)	
E. R. Smith-Owen, M.R.C.S., L.R.C.P., M.B., Ch.B. (part-time)	
L. W. Waters, M.B., Ch.B. (part-time)	

School Ophthalmic Surgeons*

A. M. Barnett, M.A., M.R.C.S., L.R.C.P., D.O.
R. C. Chaturvedi, M.B., B.S., D.O.
A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.
G. Searle, M.R.C.S., L.R.C.P., D.O.

Chest Physicians*

G. E. Adkins, M.B., B.CHIR.
J. J. Y. Dawson, M.C., M.D., M.R.C.P.
R. L. Midgley, M.R.C.S., M.R.C.P., M.B., B.S., M.D.
J. T. Smyth, M.R.C.S., M.R.C.P., M.B., B.S.

Psychiatrists, Child Guidance*

C. J. Wardle, M.D., B.S., M.R.C.S., L.R.C.P., D.P.M.
P. M. Jackson, M.B., B.Ch., D.P.M.
W. Johnston, M.B., Ch.B., D.P.M. (part-time)

* On staff of the Regional Hospital Board.

DENTAL SERVICE

Chief County Dental Officer and
Principal School Dental Officer ... F. H. Stewart, B.D.S.

County Orthodontist J. D. W. Barnett, B.D.S., D.ORTH.

Dental Officers (full-time):

G. W. B. Bateman, L.D.S., R.C.S.

Kathleen Billings, B.D.S.

J. L. Dickson, L.D.S., R.F.P.S.

D. J. Dolby, L.D.S., R.C.S.

A. R. Gammack, L.D.S., R.C.S.

H. W. Gibbs, L.D.S., R.C.S.

Audrey Hall, L.D.S. (Honiton Area from 2.1.70 to 21.2.70) (Tiverton Area
from 12.6.71 to 10.12.71)

Penelope J. Heather, L.D.S., R.C.S., B.D.S., (w.e.f. 23.2.70)

J. F. Hunt, L.D.S., R.C.S.

A. Shipley, B.D.S.

K. P. Smith, L.D.S., R.C.S. (retired 8.6.71)

J. W. Steer, L.D.S., R.C.S.

J. K. Vowles, B.D.S.

F. M. Warren, B.D.S., L.D.S., R.C.S.

H. D. Williams, L.D.S., R.C.S.

Dental Auxiliary:

Miss Jane C. Nichols (commenced 5.10.70, resigned 30.9.71)

Dental Hygienist:

Miss P. H. Turnage (resigned 31.1.71)

DISTRICT MEDICAL OFFICERS OF HEALTH

Areas	District Councils		District Medical Officers of Health	
1	Exmouth Budleigh Salterton St. Thomas	U.D. U.D. R.D.	L. G. Anderson, M.D., D.P.H. ("mixed" appointment)	
2	Ottery St. Mary Sidmouth Honiton Seaton Axminster Honiton	U.D. U.D. M.B. U.D. R.D. R.D.	R. C. MacLeod, M.D., D.P.H., D.T.M&H. ("mixed" appointment)	
3	Crediton Crediton Tiverton Tiverton	U.D. R.D. M.B. } R.D. }	N. F. Sawers, M.B. Ch.B. L. N. Jackson, B.A., D.M. G. Nicholson, M.D., D.P.H., F.R.C.S. (combined appointment)	
4	Barnstaple Barnstaple South Molton Ilfracombe Torrington Northam Bideford Holsworthy Great Torrington Bideford Lynton	M.B. R.D. R.D. U.D. R.D. U.D. M.B. R.D. M.B. R.D. U.D.	E. Williams, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment) Stella C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P. Deputy Medical Officer of Health C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P. N. B. Betts, M.B., B.Chir., F.R.C.S., L.R.C.P. M. P. Nightingale, M.R.C.S., L.R.C.P.	
5	Salcombe Kingsbridge Kingsbridge Plympton St. Mary Tavistock Totnes Totnes Buckfastleigh Dartmouth	U.D. U.D. R.D. R.D. R.D. M.B. R.D. U.D. M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H. Mary E. Budding, B.Sc., M.B., B.Ch., D.P.H. Deputy Medical Officer of Health ("mixed" appointments)	
6	Ashburton Dawlish Teignmouth Newton Abbot Newton Abbot	U.D. U.D. U.D. U.D. R.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H. A. H. Halstead, M.B., B.S., D.P.H. Deputy Medical Officer of Health ("mixed" appointments)	
7	Okehampton Okehampton	M.B. R.D.	Mary E. Budding, B.Sc., M.B., B.Ch., D.P.H. ("mixed" appointment)	

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Area and Population

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>
Area (acres)	102,187	1,510,148	1,612,335
Population (estimated mid-1970)	193,700	248,350	442,050
Population (estimated mid-1971)	199,040	254,680	453,720
Number of Municipal Boroughs, 8; Urban Districts, 16; Rural Districts, 16; Total, 40.			

Vital Statistics*

	<i>Administrative County</i>		<i>England and Wales</i>	
	1970	1971	1970	1971
<i>Live Births:</i>				
Number	5,882	5,895	784,482	783,165
Corrected rate per thousand population...	16.5	16.1	16.0	16.0
Illegitimate live births (389) percent of total live births	6.41	6.59	8.25	8.38
<i>Stillbirths:</i>				
Number	68	72	10,341	9,898
Rate per thousand total live and stillbirths	11.40	12.1	13.0	12.48
Total live and stillbirths	5,950	5,967	794,823	793,063
Infant deaths (deaths under one year) ...	107	78	14,269	13,726
<i>Infant mortality rates:</i>				
Total infant deaths per thousand live births	18.19	13.23	18.19	17.53
Legitimate infant deaths (70) per thousand legitimate live births	18.71	12.71	17.50	16.92
Illegitimate infant deaths (8) per thousand illegitimate live births	10.61	20.56	25.90	24.15
Neo-natal mortality rate (deaths under four weeks (50) per thousand live births	13.26	8.48	12.32	11.64
Early neo-natal mortality rate (deaths under one week (40) per thousand live births)	10.88	6.79	10.62	9.90
Peri-natal mortality rate (stillbirths and deaths under one week combined (112) per thousand total live and stillbirths)	22.18	18.77	23.48	22.25
<i>Maternal mortality (including abortion):</i>				
Number of deaths	1	1	146	133
Rate per thousand total live and stillbirths	0.17	0.17	0.18	0.17

* See Statistical Appendix for further details.

PART II

CARE OF CHILDREN

A. INFANTS AND PRE-SCHOOL CHILDREN

Immunisation and Screening Procedures
Dental Care

B. CHILDREN OF SCHOOL AGE

Administration and Records—School Health Service
Premises: Swimming Pools
Health Visitor and School Nurse
Periodic Medical Inspections
Child Guidance
Hearing Assessment
Speech Therapy
Handicapped Children
Dental Care

CARE OF CHILDREN

A. BABIES AND PRE-SCHOOL CHILDREN

Since 1st January, 1970, we have recorded the birth of every child in the County on the local authority computer. This will prove of great value in forward planning for the Health Department and also for the Education and Social Services Departments. We have also recorded on computer details of children at risk and suffering from handicaps; gradually our present filing system for these children will be superseded by the computer record.

The computer record is also used for immunisation consents and for sending out appointment lists of children requiring the various immunisations and recording injections given. Parents can choose whether the general practitioner or local authority undertakes the immunisations and increasingly general practitioners are undertaking them. We have offered doctors the choice of the two schedules of immunisation for their patients. Those children whose immunisation procedures are undertaken by the local authority are immunised according to the Department of Health and Social Security schedule commencing at six months, but a number of general practitioners prefer to use the schedule giving earlier protection against pertussis but requiring an extra booster injection at 18 months.

After some initial teething problems the system has now settled down and is running efficiently. We hope that it will be possible in due course to continue this computer record with school health records, and discussions are taking place with neighbouring authorities.

Smallpox Vaccination

Smallpox vaccination was discontinued as a routine procedure on the advice of the Department of Health and Social Security in 1971.

Rubella

By immunising girls who have not had rubella naturally at the age of 11–13 years it is hoped to prevent congenital abnormalities which can result when a woman has rubella in the first three months of pregnancy.

In 1970 this immunisation was made available and there has been a good response.

Measles

Measles vaccination is now available for all children requiring it. It is now being offered to children from the second year of life and to any older child who has not had natural measles. This is proving a popular vaccination.

T.B. Vaccination

B.C.G. Vaccination is offered to school children of over 11 years of age, and also young adults attending colleges, technical schools, etc. Parents have the opportunity of giving their consent to this procedure and the vaccination is carried out by specially trained medical officers.

Record Cards

Special personal record cards are issued to mothers attending welfare centres, and supplies are available to general practitioners on request. The importance of having these cards completed after each injection is stressed to the parents, who are also advised to produce it whenever a child attends a doctor or hospital following an accident.

Phenylketonuria

All babies are tested by the Guthrie blood test for phenylketonuria, but no positive cases were found in 1970 or 1971.

Congenital Defects

These continue to be notified to the Registrar General's Office and every effort is made to ensure that details are complete and accurate on the discharge forms prepared at the end of each puerperium. This is necessary not only for the Registrar General's Research Project but also as a basis on which the Health Department prepares the observation and handicap registers which are maintained for any given child throughout pre-school and school life.

Child Health Clinics

At the end of 1971 68 clinics were operating. The sessions at the Barnstaple Child Health Clinic were taken over by the the three group practices in the town at the beginning of 1971 and these sessions are now held in the doctor's surgeries.

Number of purpose built clinics or health centres	...	...	...	33
Number adapted and in full-time use	...	...	...	5
Number used on a sessional basis	...	...	...	26
Doctors' Surgeries	...	...	...	4

In 1970 and 1971 the emphasis on developmental paediatrics increased. A number of medical officers have been to various courses of training for this work and have found considerable interest and satisfaction in undertaking it. Some of our Child Health Clinics are staffed by general practitioners but unfortunately, because of other commitments, they have not been able to undertake as much training as local authority staff.

Use has been made of the Society of Medical Officers and Health form in both the older and revised versions; both the forms have their supporters, but undoubtedly the revised form with its check-list of points to be looked for is likely to produce a more comprehensive record.

One has only to do some simple arithmetic to realise that the establishment of doctors is quite insufficient to undertake all of the examinations required for all children in the area. Increasingly health visitors are assisting in this work. I am most grateful for the help which Dr. W. Burgess (consultant paediatrician North Devon) gave in demonstrating child development to health visitor, groups throughout the County. Subsequent to this the health visitors have undertaken responsibility for part of the testing. This has proved a satisfactory arrangement and the health visitors have carried out the work most effectively and conscientiously.



Development assessment test by health visitor.

Although there is less emphasis now on informal interviews at the clinic there is undoubtedly a need for some clinic time to be set aside for an anxious mother to have a chat with the medical officer or health visitor, and most medical officers are keeping a small proportion of their time for this. All developmental assessment work is arranged by appointment and this free time must be planned in the programme.

Dental Care

While many parents remain unaware or unconvinced of the need to have their pre-school children examined by a dentist from the age of three, further progress was made over the past two years in coverage of the County's three and four year olds. In 1971, more toddlers were examined (2,062) than ever before, many resulting from visits by dental officers to playgroups and child health clinics, and from the reminder to parents on the school consent form that pre-school children should see a dentist regularly. This increase is welcomed, but the County Dental Service now examines only one in six of the total pre-school population, and clearly there is room for further dissemination of information to, and encouragement of, parents to seek dental care for their young children.

The treatment pattern for the pre-school age group has been biased further on the side of increased conservation of teeth, e.g. in 1971, six deciduous teeth were filled for every tooth extracted—a very encouraging trend.

B. CHILDREN OF SCHOOL AGE

School Medical Records

The withdrawal of school medical records from schools when a health centre is available in the locality has continued in 1970 and 1971. Medical officers are finding the benefit from having their records immediately to hand and available after school hours and during school holidays. The supplementary card is available in schools for use by all professional workers involved in the care of a child.

Educational Welfare Officers

With the formation of the Social Services Department in April, 1971, two-thirds of the educational welfare officers were transferred to the Social Services Department. This undoubtedly left a temporary gap in the services available to the child in the schools, for example in cases of truancy, poor school attendance and poor physical care. Discussions have taken place with both the Education and Social Services Departments to fill this gap and head teachers will themselves liaise with the School Health Service and Social Services Department in this type of problem.

Premises for Medical Inspection

Medical officers remain dissatisfied with the conditions for medical inspection in many schools though gradual improvements are being made, especially in the Secondary schools.

School Swimming Pools

The number of pools provided by schools in the county has increased rapidly since the first pool was installed in 1959. The present number is esti-

mated to be 200, whilst a considerable number of new pools should be in commission during the summer of 1972.

There have been a number of dramatic changes in the construction of pools and in the filtration and chlorination systems. As a result, we have reached the point where a number of the older pools require the expenditure on them of substantial sums of money, whilst the cost of chemicals for treatment has also risen to a considerable sum.

It is not necessary to repeat the remarks which have been made in previous Annual Reports regarding correct pool maintenance, as these are now incorporated in an eight-page booklet and two supplements, issued to all head teachers, in which there is a very full description of the necessary methods to be adopted.

Health Visitor and School Nurse

In the school health service the health visitor is responsible for seeing that school medical inspections, testing of vision and hearing, and hygiene surveys are carried out. She is available to discuss with teachers the background of children who present a problem. Clinic nurses give assistance to the health visitors in the schools.

As a realistic establishment of school nurses becomes available we are going forward with the scheme of basing a nurse at a comprehensive school. We have felt that a nurse should be based full-time if the school has 1,500 pupils or more; for smaller schools a nurse has been appointed on a proportional basis. This scheme has proved most successful and head teachers have been enthusiastic in their support of it. We have had a number of requests from schools asking for the urgent provision of such a nurse.

Apart from hygiene inspections and first aid, the nurse is able to undertake simple health education and counselling on medical matters. It is hoped that this scheme will be extended to other comprehensive schools.

Health education is an important part of the health visitor's work and over the years she has steadily increased the amount of work in this field. Many schools ask her to advise or participate in programmes and youth clubs and other organisations request talks on a number of subjects. Students from hospitals, health visitor training schools, universities and teacher training colleges accompany health visitors for varying periods for observation and practical work.

Periodic Medical Inspections

More emphasis and time is being given to the school entrant, and increasingly the selective form of examination is being used for the intermediate pupil.

The number of children classified "unsatisfactory" will depend very much on the medical officer doing the examination. Standards may differ, and therefore these figures do not give a reliable guide to the standard of health of the children examined.

Return of Defects by Medical Inspection in the year ended 31st December, 1971.

Note: All defects noted at medical inspection as requiring treatment are included in this return, whether or not this treatment was begun before the date of inspection.

RESULTS OF ROUTINE AND SPECIAL MEDICAL EXAMINATIONS

Defect Code No.	Defect or Disease	Periodic Inspections		Special Inspections	
		No. of defects		No. of defects	
		Requiring treatment	Requiring to be kept under observation but not requiring treatment	Requiring treatment	Requiring to be kept under observation but not requiring treatment
	(1)	(2)	(3)	(4)	(5)
4	Skin... ..	272	539	11	19
5	Eyes—(a) Vision	925	700	39	17
	(b) Squint	210	198	7	12
	(c) Other	35	64	—	1
6	Ears—(a) Hearing... ..	143	1,046	18	55
	(b) Otitis Media	60	303	4	12
	(c) Other	42	53	6	2
7	Nose or Throat	167	853	14	32
8	Speech	135	322	16	28
9	Lymphatic Glands	24	208	—	5
10	Heart	27	197	—	5
11	Lungs	69	431	3	15
12	Developmental—				
	(a) Hernia	27	95	4	1
	(b) Other	74	307	12	15
13	Orthopaedic—				
	(a) Posture	51	186	5	3
	(b) Feet	117	413	5	13
	(c) Other	61	257	1	9
14	Nervous system—				
	(a) Epilepsy	41	86	3	4
	(b) Other	16	111	2	9
15	Psychological—				
	(a) Development	47	365	9	24
	(b) Stability	75	355	5	30
16	Abdomen	27	103	2	2
17	Other	89	366	4	11

Investigation of Vermin or Head-Lice

In 1970 and 1971 we had reports from health visitors in various parts of the County that head-lice being encountered were larger than had ever been seen before in the nurses' experience. In addition these head-lice were proving increasingly resistant to the treatments which had previously been effective. I understand that this was a nation wide problem and in 1971 the manufacturers produced new treatments which should prove more satisfactory. These are being used experimentally in schools.

Infestation with Vermin

- (i) Total number of examinations in the schools by the school nurses or other authorised persons 46,274
- (ii) Total number of individual pupils found to be infested ... 128...

Administration—School Health Service

In 1970 and 1971 we were fortunate to have a full complement of school medical officers (9.5), and as a result the work of the school health service was up to date.

The number of children on the school registers are as follows:

	1971
Primary Schools	39,688
Secondary Schools, Grammar Schools, and Comprehensive Schools	25,327
Special Schools	550
Total	<u>65,565</u>

Direct control of this service is vested in the school health sub-committee of the Education Committee, and we are particularly fortunate in this county in the friendly and effective liaison between Education and Health Departments.

PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By year of birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected	
		Satisfactory No. (3)	Unsatisfactory No. (4)
1967 and later	75	75	—
1966	3,162	3,161	1
1965	2,330	2,329	1
1964	958	955	3
1963	2,488	2,486	2
1962	1,869	1,867	2
1961	1,063	1,058	5
1960	1,478	1,474	4
1959	1,823	1,820	3
1958	638	636	2
1957	995	902	3
1956 and earlier	2,673	2,064	9
Totals	18,952	18,827	35

Other Inspections

Number of special inspections	567
Number of re-inspections	2,803
Total	<u>3,370</u>

Pupils found to require treatment at periodic medical inspections (excluding dental diseases and infestation with vermin).

Notes: Pupils found at periodic inspections to require treatment for a defect are not excluded from the following Table by reason of the fact that they were already under treatment for that defect. The Table relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the sum of columns (2) and (3).

PUPILS REQUIRING TREATMENT

Age Groups Inspected (By year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1967 and later	2	2	3
1966	115	282	311
1965	90	189	234
1964	36	115	97
1963	91	230	252
1962	84	152	194
1961	57	94	115
1960	72	89	116
1959	129	133	187
1958	31	47	72
1957	54	60	201
1956 and earlier	164	290	369
Total	935	1,683	2,151

CHILD GUIDANCE

*Report of the Medical Director—
Dr. Christopher J. Wardle, Child Guidance Clinic, Exeter.*

The pattern of work during 1971 has followed that of the previous two years. We welcome the growing trend for children to be referred younger and before their problems are too well established. Many problems stem from an overall family difficulty and we are trying to see the whole family wherever possible. Fewer children with problems of delinquency are being referred, but far more with family relationship difficulties. Difficulties in family relationships and emotional disturbances in children are those problems we can help most effectively, but it is worth noting by those who refer children, that we can do little without the co-operation and goodwill of the parents. The Social Services Department is better geared for helping the problem family who will often not be willing to co-operate, and even if willing, the material and social situation is so bad that little can be done by individual psychiatric treatment. We feel it important that all those concerned should recognise the need for early referral of certain problems which can be treated easily if seen near their beginning and may become impossible to treat once well established.

Overall the picture of the Child Psychiatric Service for this area continues to be a very positive one, and we now have outpatient services in three main centres, at Exeter, Barnstaple and Holsworthy, while people in the South and West of the county are served from centres in Torbay and Plymouth. The close integration of the in-patient and out-patient services continues to thrive and the possibility of admitting children with acute emotional disturbances quickly and easily, makes our work very much more efficient and successful. We have now established an adolescent unit for young people aged 15=18, associated with the Dryden Inpatient Unit for children. This Unit takes 12 adolescents and is already in full swing. We feel it is important that people working in the community should be aware of this service for adolescents and should realise that the Child Guidance Clinic takes all young people up to the age of 17. There is an evening clinic for working teenagers at the Royal Devon and Exeter Hospital, held on the first Thursday of each month from 5.30 p.m. Appointments are

made through the Appointments Clerk at the Royal Devon and Exeter Hospital (Southernhay). Although we know that there are many young people in the community with grave problems, very few are being referred for help, and we believe this may be because people are not aware of the availability of suitable services for them. We think it would be a worthwhile exercise during 1972 to try to ensure that all those in the age group 15–18 are receiving the help they need. Perhaps all those reading this report could play a part in this?

Report of Dr. Paul M. Jackson—

Child Psychiatric Service, Child Guidance Clinic, Barnstaple

During the last year we have unfortunately lost Mr. Evans, our Educational Psychologist, and we have not been able to get a replacement. This has led to a decline in the quality of the work the Clinic has been able to produce.

We continue to see an increase in the number of behaviour disorders referred, and on the whole I do not think these have been satisfactorily treated due to the fact it is very difficult to get the co-operation of the parents over any period of time. There has also been an increase in the number of referrals from the School Counsellors, through the Headmasters, and also through the School Medical Service. It is also interesting to note that the referrals continue to come in, and if anything, there has been a slight increase over last year; this compares very favourably with the fall in cases in the Exeter area. There appears to be very little liaison between the School Counselling Service, School Medical Officers and the Clinic. Another rather interesting feature, that in spite of the very large number of behaviour problems that have been referred to the Clinic there has only been a small increase in the number of boys referred.

HEARING ASSESSMENT

The work of the hearing assessment teams has gone forward satisfactorily. We still have the five area teams comprising of a specially trained medical officer, peripatetic teacher for the partially hearing and audiometrician. The team may refer any child about whom they have concern to a combined hearing assessment clinic at which an ear, nose and throat consultant is in attendance, and in addition other workers such as paediatricians, psychiatrists, speech therapists, teachers and health visitors may also attend. This arrangement works very satisfactorily and there is a close and friendly liaison between the workers.

AUDIOMETRY

Hearing tests for infants are carried out routinely on all children according to the methods recommended by Manchester University: health visitors do this before the first birthday. An ideal arrangement would be for two health visitors to undertake this test in all cases, but in a rural area this is not possible, and any child about whom the health visitor is not happy is re-tested at a clinic when two health visitors are available.

“Sweep” testing of all children during their first year in school has been undertaken since 1969. This work is done by specially trained school nurses and the children who fail the “sweep” test twice then have a full audiometric test by audiometricians and the case is then reviewed by the Departmental medical officer. In 1971 after discussion with all those involved it was agreed that this “sweep” testing should be done again when the child reaches the age of eight and the school nurses, who have become extremely adept at testing, have kept up to date with this additional work.

SPEECH THERAPY SERVICE

South and West Devon

1971 has seen considerable changes in the South West Devon Speech Therapy service. Mrs. Hampson left the Newton Abbot/Crediton district in order to read Linguistics at Exeter University. In view of the very heavy numbers in this particular area it was divided and Miss Day was appointed in the Crediton area, covering clinics at Crediton, Okehampton, Chagford and Holsworthy, where much of her work is being done in schools. Miss Sykes was appointed to the Newton Abbot area where, in addition to her clinics, she is working in close co-operation with the new Diagnostic Unit in Kingsteignton and the Newton Abbot Playgroup.

Speech Therapists have in the past been available to advise the Training Schools. However, within this last year since the E.S.N. and S.S.N. Schools were transferred from the Health Department to Education, Speech Therapists have worked in close co-operation with the teachers and are included in the teams of remedial teachers, teachers of the partial hearing and educational psychologists, and indeed are working very much more generally with their colleagues in Education.

Adults are continuing to be treated on the basis of not more than one session of the full-time Therapist's time, though in fact this works out at less than this, as they are still carrying very heavy case-loads and long waiting lists. The figures for South West Devon at 31st December, 1971, for children were as follows:

On waiting list	...	...	...	...	...	...	...	102
Discharges	...	...	...	...	...	...	...	244
Under treatment or observation	...	...	...	...	...	...	...	333

On numerous occasions, Speech Therapists have been asked to contribute, with other colleagues within the Health and Education services at School Staff meetings, Parent Groups and Playgroups.

East and North Devon

Growing awareness of the needs of children with language problems led to the setting up in November, 1969, of a special class by D.C.C. Education Department and Health Department to provide remedial teaching and intensive speech therapy for a group of children who have great difficulty in learning to use or understand speech.

The problems of these children do not fall into one diagnostic category. The variety and range of disorder found in the groups necessitate frequent individual speech therapy sessions and a very flexible remedial programme.

Some of the children were unable to learn to speak or read by normal methods; others had been so retarded by their late language development that, in spite of their normal intelligence, they did not benefit from the teaching at the local schools.

In order to retain links with the community the children attend the unit on a part-time basis. It is anticipated that most of the children will return to their own schools after a period at the unit. Since April, 1970, Exeter City took over the responsibility for organising and staffing the unit at which City and County children are placed. It is hoped that, when possible, a similar unit will be established in North Devon.

Miss M. Williams, D.C.C. remedial teacher who pioneered the class, has a special responsibility for the education of children with late language development and her co-operation has been greatly appreciated by all the therapists with whom she has been working.

Miss Fisher advised on the programme of the course for Speech Therapists organised by the Provincial Councils for Local Authorities Services in the South West, and acted as joint Chairman/Tutor to the course. Lectures have been given to Speech Therapists, teachers and playgroup leaders.

Seminars, demonstrations, a course of lectures for third year students at Rolle College of Education continue.

A talk was given to a group of medical consultants at Plymouth on the needs of children with severe language disorders.

Demand for speech therapy services increases from all quarters. Recently, the recognition of the importance of pre-school years and the needs of E.S.N. and S.S.N. children has given rise to requests for advice and treatment.

Assessment, advice and support to parents is given as soon as the child has been referred, but unfortunately, owing to the long waiting list for treatment, it may be over 12 months before regular appointments can be offered and many children never receive more than a fraction of the help they require.

At present, the establishment in East and North Devon is one senior and the equivalent of three full-time therapists. The guide line laid down in 1946 for one speech therapist per 10,000 school children is clearly unrealistic today.

As there is no provision outside Exeter for adults who have lost their speech, a few sessions of the County Speech Therapists' time is allocated to them, but this amounts to less than one full-time therapist for the entire population of Devon.

During these two years, the interest shown in children with speech problems and the realisation of the complexity of speech pathology by both professional colleagues and the general public has been gratifying to those of us who have worked for so long in this field.

SCHOOL OPHTHALMIC SERVICE

This service has proceeded smoothly throughout the year. Health centres offer much better facilities for the testing of children's eyesight than the schools, and are being used increasingly.

HANDICAPPED CHILDREN

As mentioned earlier a register of children considered at risk or handicapped is maintained in County Hall, partly on computer and partly on file. This record is compiled from discharge letters from maternity hospitals, reports from paediatricians and other consultants, medical officers, health visitors and other workers. Children on this register are seen regularly by the health visitor at home or in the child health clinic, and if possible are seen regularly by the medical officer at the clinic. Increasingly the liaison between the consultant concerned, family doctors and the local authority staff is improving and we are also grateful for the help of the Social Services Department.

It is unfortunate that the number of educational psychologists is not sufficient to allow as much testing of pre-school children as we would like.

Both the Education and Social Services Departments will pay for handicapped children to attend playgroups and this is of tremendous benefit to certain of these children. We are fortunate that in Devon the number and quality of playgroups is so high.

Six months before a child reaches school age, the departmental medical officer is asked to give his opinion concerning future educational needs, so that suitable education can be arranged before the child becomes five years old. Throughout his schooldays the child is under close surveillance.

All cases of children who are recommended for ascertainment as educationally subnormal are discussed between the adviser for special education and the senior medical officer for child health and an agreed recommendation is given to the Chief Education Officer.

Those physically handicapped children who have to attend boarding schools are visited by the medical officers during the summer holidays each year and a report is submitted; this is considered by the senior medical officer and the adviser for special education in conjunction with the report from the school, and any necessary action taken.

At E.S.N. schools and hearing assessment clinics all children coming up to school-leaving age are considered by an assessment panel to plan the child's future and ensure that suitable employment or occupation is arranged. Local medical officers also ensure that careful thought is given to the future of physically handicapped children attending normal schools and, if necessary, local co-ordinating meetings are held.

The number of handicapped children registered in the department at 31st December, 1971, was 1257 children of school age and 375 aged two to five years. They fall into the following categories:

								5 to 16	2 to 5
Blind	...	...	...	...	...	...	...	6	2
Partially sighted			...	...	...	...	...	25	3
Deaf	...	...	...	...	...	...	...	24	1
Partially hearing		...	...	...	...	...	...	63	1
Physically handicapped			...	...	...	...	...	173	157
Delicate	...	...	...	...	...	...	...	167	126
Speech defect	...	...	...	...	...	...	...	15	1
Epileptic	...	...	...	...	...	...	...	52	26
Maladjusted	...	...	...	...	...	...	...	42	—
Educationally subnormal			...	...	...	...	...	690	58

Partially Hearing and Deaf Children

Deaf and severely partially hearing children are educated at the Royal School for the Deaf in Exeter or Hartley House School, Plymouth. These schools have nursery groups and the children are therefore able to have help in the pre-school years, which is of such immense importance for the deaf. Partially hearing units are attached to primary schools in Barnstaple and Dartington. It is hoped that a further unit will be established in the Honiton area in 1972.

However, the great majority of children with a hearing defect manage in normal schools with the help of the peripatetic teachers of the partially hearing. They regularly attend the hearing assessment clinics.

Delicate and Physically Handicapped Children

Our policy is that wherever possible these children should attend normal schools, and with the co-operation of teachers and parents, children with quite severe handicaps can thrive in normal schools. We are fortunate in having three schools for delicate and physically handicapped children from 5–16 years in the area, namely Dame Hannah Rogers School, Ivybridge, The Woodlands School, Plymouth and Steps Cross School at Torquay. County children are placed at all of these schools.

In addition children can be placed at the Trengweath School for Spastics at Plymouth and Vranck House School and Centre at Exeter. Both these schools, which were founded by voluntary efforts, offer education and therapy and have proved of tremendous benefit to children within their respective areas. Both schools will take children with severe physical handicaps other than cerebral palsy and have shown great sympathy in offering help where it is needed.

Educationally Subnormal Children

Although some educationally subnormal children may have to wait for a place in a special school the vast majority can be offered special education suitable for their needs even though this may require boarding. As mentioned in the last report there is an increasing reluctance on the part of parents to allow their children to attend a residential school and I am delighted to see increasing emphasis being placed on the establishment of assessment classes attached to either normal or E.S.N. schools. Children can be placed in these classes on an informal basis so that their assessment may take place over a period of several months. A very much more reliable assessment of children's ability can be made and a suitable educational plan agreed.

Non-communicating/Auditory Imperceptive Children

In 1970 a small educational unit was set up for these children whose diagnosis and education presents such very great problems. We were fortunate in that the education authority was able to find a most excellent teacher for the unit and the local authority is indebted to the Royal West of England School for the Deaf for offering temporary accommodation at the school before more permanent arrangements could be made. In 1971 the unit moved to the Beacon Heath School in Exeter and this has proved a satisfactory arrangement. Children from both Exeter City and Devon County attend the unit, some on a full-time basis and others part-time, thus enabling them to keep links with their local schools. The assessment of the children and the administration of the unit have presented many problems, especially because so many people have been involved; but all have learnt a great deal from this experiment; good local facilities have been available for children who otherwise would have had to attend schools many miles away, or alternatively schools without special facilities. We are most grateful for the help given by the Exeter City Health and Education departments in establishing this unit.

Mr. F. H. Stewart, Chief Dental Officer and Principal School Dental Officer has presented the following report for 1970 and 1971—

THE SCHOOL DENTAL SERVICE

The current establishment figure of 16 dental officers was reduced to an effective staffing position of 15.2 dental officers in 1970, and 14.9 in 1971, through illness in both years, and the inability to fill the full-time vacancy in Tiverton, which arose in June, 1971, on Mr. K. P. Smith's retirement. The loss of the dental hygienist, Miss Pamela Turnage, early in 1971, and the departure late in the year of the dental auxiliary, Mrs. Jane Nichols, created two further vacancies. After a period of several years with a stable staffing position, all three full-time vacancies remained unfilled at the end of 1971, despite repeated advertising which, in the case of the dental officer and dental hygienist posts, has now extended over a period of 12 months. In order to maintain a high

standard of provision of dental care to the community which it serves, the County Dental Service must attract and retain its fair share of suitable young dental graduates. The failure to do so in 1971 is the most disappointing and disturbing feature of the year.



A view from the entry door shows the waiting room and the lack of apprehension of those waiting. The full width bench seat can also serve as a recovery couch should this prove necessary.

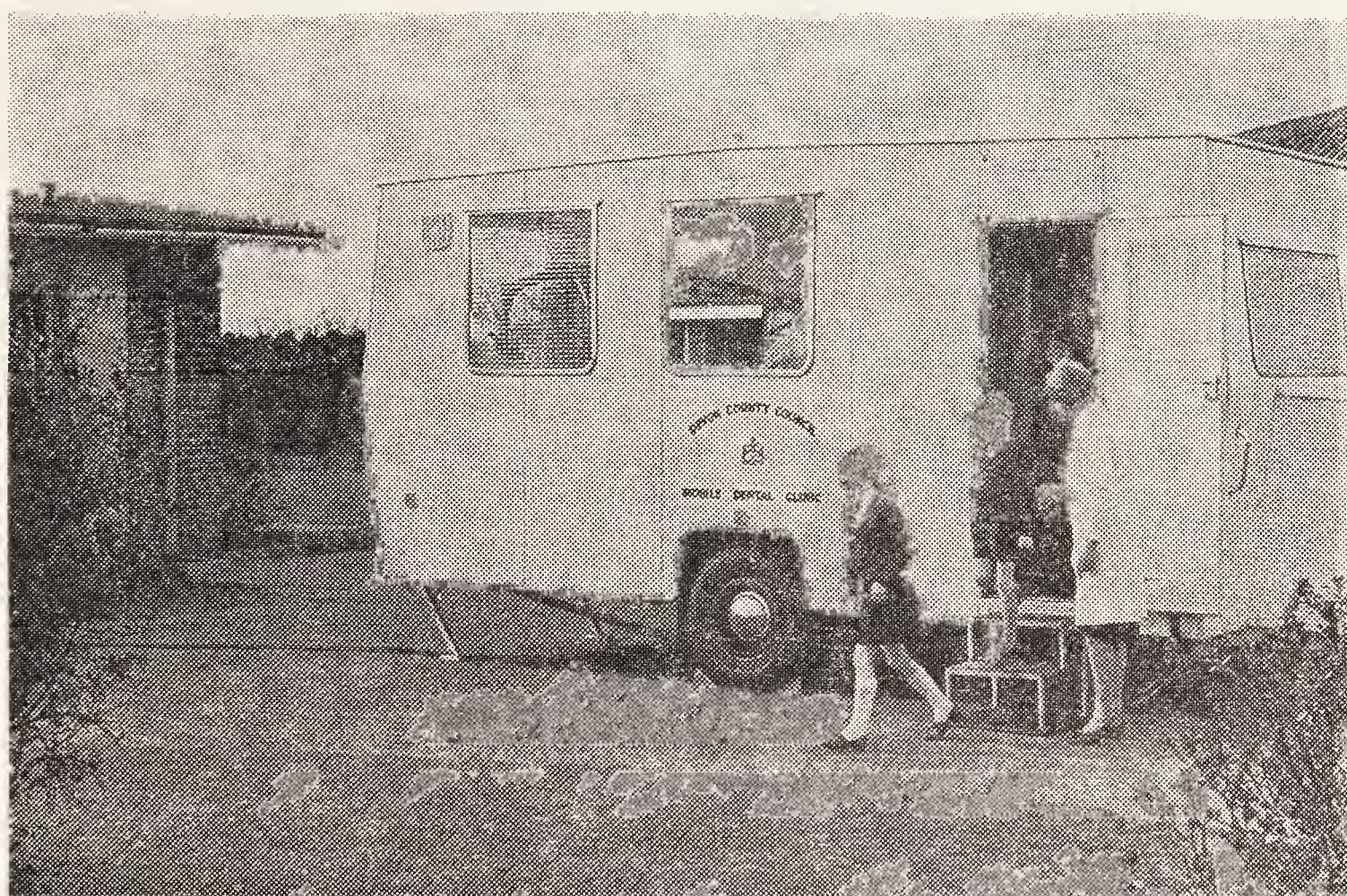
Two new mobile dental clinics, redesigned to offer bright, modern operating conditions which are greatly appreciated by operator and patient, were brought into service, enlarging the fleet to 13. Further progress was also made in replacing old equipment in fixed clinics, and a programme of installing appropriate mains electric and water services at schools for mobile clinics is well under way. These two programmes will be continued in future years, to ensure optimum efficiency and consideration for patient and operator in the dental surgery.

The collective efforts of dental officers to sustain and improve upon clinical efficiency and effectiveness, resulted in increased output in 1970 and 1971, a factor which prompted favourable comment from the Department of Education and Science following the visit of their dental officer in 1971 to review the County Dental Service. The emphasis has again been on conserving teeth, with 30 permanent teeth filled for every tooth extracted because of decay, and an equivalent 4 : 1 ratio for deciduous teeth. This trend is welcomed but can only continue to improve if regular six-monthly examination, followed by the offer of treatment, is extended to more children each year until every child is included in this regimen.

The statistical section for 1970 and 1971 in Appendix H shows that the proportion of children examined each year is now falling slightly. While it was possible to examine almost 100% of the school population in 1969, only 93% of children received an annual inspection in 1970 and 1971, and in both years



The dental surgery, viewed from the waiting room, with the bright spacious interior clearly shown. The surgery is equipped to the standard of a fixed clinic and the mobile dental units permit the dental surgeon to work standing, as shown, or seated behind the patient.



When treatment has been completed, the classroom is only a few seconds walk away.

only one-third of these children received more than one examination in the year. The decrease can be attributed in part to staff illness and a vacancy for part of one year, but the overriding factor has undoubtedly been the increase in school population over recent years. Devon's school population has risen by 2,000 children a year for at least five years, during which time there has been no increase in dental officer staff. Clearly a situation has now been reached when improved efficiency in clinical routine cannot any longer cope with this ever rising school population, and staff increases must become a priority if the standards of provision of dental care, as judged by previous performance in Devon, are to be maintained let alone surpassed.

Regular six-monthly visits to junior training centres have been maintained, with mobile dental clincis proving invaluable in reducing inconvenience to paitents and teaching staff at the centres. The benefits arising from this systematic routine care are now becoming apparent, since the volume of treatment found to be necessary at each visit of the dental officer is gradually diminishing. The school for mentally subnormal children at Stoke Lyne Hospital became a County responsibility in 1971 and an initial examination confirmed that some children were unable to co-operate with conventional treatment methods under local anaesthesia. Arrangements were made for them to be treated under general anaesthesia in Exmouth Hospital, by Miss Kathleen Billings, the County Dental Officer for the area. A programme of providing comprehensive dental treatment on a day stay basis is now functioning extremely well, and we are indebted to our anaesthetist, Dr. D. W. Geidt, and the staff in Exmouth Hospital whose co-operation made this scheme possible.

Dental Research and Epidemiology

Hazards from Mercury and Mercury Vapour. Following concern by the dental profession in 1970 at the possible hazards from mercury and mercury vapour in dental surgeries, a detailed study of the problem was conducted in several fixed and mobile clinics by the Chief Dental Officer and Dr. G. N. Stradling, Radiochemist at the National Radiological Protection Board. A paper on the subject was published in the British Dental Journal in 1971, where the precautions to counteract possible hazards from mercury vapour were outlined. These precautions have been incorporated into the daily routine of dental staff in the County and will reduce the potential hazards to negligible proportions.

Survey of five year old Children—1970. In 1970, dental officers conducted a survey of 1,150 five year old children (approximately 20% of the total number in this age group). The survey was carried out at the time of routine school dental inspection, and while standards were set for the examination procedure, examiner variability was evident in the results. Despite these shortcomings, the findings provided useful information which is summarised below:

DENTAL CARIES PREVALENCE—5 YEAR OLD CHILDREN—1970

	No. examined	Average No. per child of				% age of children with 10+ def teeth	% age of children with no def teeth
		'd' teeth	'e' teeth	'f' teeth	def teeth		
Boys	598	2.7	0.7	1.2	4.6	10.5	20
Girls	552	2.9	0.6	1.3	4.8	11.0	19
Total	1,150	2.8	0.7	1.2	4.7	10.8	19

'd'=Decayed; 'e'=extracted; 'f'=filled, otherwise sound.

Survey of 12 year old Children—1971. Following their request to conduct a survey of caries prevalence in 12 year olds in the Tamar Valley to study the effects on dental caries of mineral constituents in soil, Prof. P. M. C. James and Dr. R. J. Anderson, from the Department of Dental Health, Birmingham University, examined all the 12 year olds attending Tavistock Comprehensive School, as the study group, and all children in the same age group attending Okehampton Comprehensive School, to serve as controls. This study encompasses those 12 year olds resident since birth within a prescribed area of the Tamar Valley, in Devon and Cornwall, for which information about mineral constituents of soil is already available. Prof. James and Dr. Anderson have yet to complete the Cornwall area of the study, and their findings are awaited with interest.

The opportunity was taken to apply Prof. James' examination technique to a study of 12 year old children attending other schools in different parts of the county. Only one examiner was used, only permanent teeth were scored for caries and all the 12 year olds in each school on the day of examination were included. The schools were not randomly selected, but the findings are still valuable and are summarised below:

DENTAL CARIES PREVALENCE—12 YEAR OLD CHILDREN—1971

School	No. examined	Average No. of teeth at risk per child	Average No. per child of				No. of children with no DMF teeth
			'D' teeth	'M' teeth	'F' teeth	'DMF' teeth	
Axminster	90	24.5	1.9	0.8	4.0	6.7	—
Braunton	82	24.4	2.0	0.4	3.0	5.4	1
Cullompton	70	24.3	3.1	0.6	3.0	6.7	—
Dawlish	77	24.2	1.7	0.2	4.6	6.4	—
Ivybridge	92	23.2	1.4	0.2	3.4	5.0	1
Torrington	99	23.3	1.6	0.3	2.6	4.5	1
Uffculme	67	24.3	2.0	0.8	3.3	6.0	1
Total	577	24.0	1.9	0.5	3.4	5.8	4

'd'=Decayed; 'M'=missing, extracted for caries; 'F'=filled, otherwise sound.

The disparity between the DMF rates in the two lowest areas quoted (Ivybridge and Torrington) and the rates for other schools are explained in part by fewer teeth being at risk per child in both these schools. There remain regional differences in caries prevalence in different parts of the county which cannot be explained on the basis of this one survey.

Both surveys indicate that on average almost a quarter of the teeth of 5 and 12 year old children examined are affected by decay, and that very few children—one in five of the five year olds and less than 1 in 100 of the 12 year olds—have no decayed, missing or filled teeth. Additionally, one in nine of the five year olds have 10 or more teeth affected by decay, which is a sobering thought in view of Devon's reluctance to implement fluoridation of water supplies.

The surveys indicate that 60% of the caries in five year olds and 30% in the 12 year olds, was untreated. Information was also obtained from clinical observation at the time of examination, about attendance patterns for treatment either at a dental practitioner or school dental officer. It was estimated that 53% of five year olds regularly attended a dentist for routine care, and the remainder either attended only for the relief of pain (13%) or had never seen a dentist before (34%). Among the 12 year olds, 30% of boys and 24% of girls were thought to attend a dentist on a casual basis only, i.e. did not make regular visits for a check-up. Devon is fortunate in having general dental practitioners who treat children willingly and well, and in having an efficient school dental

service. Despite this relatively good dentist to population ratio, both in the general dental service and the school dental service, the above figures leave no room for complacency, since the need of all children to have comprehensive dental care on a regular six-monthly basis is not being adequately met.

Postgraduate Study

Three dental officers in 1970, and four in 1971 attended a one-week refresher course on childrens dentistry at the Eastman Dental Hospital, a pattern which will continue in the future. The County Orthodontist attended a specialised course in orthodontics in 1970, and the Chief Dental Officer is currently attending the course in Bristol for the Diploma in Dental Public Health. Attendances at such postgraduate courses are an essential prerequisite for an efficient, up-to-date dental service, and the courses in dental public health could prove particularly valuable in this respect.

The County Dental Service enjoys the co-operation of a great many people each year. From the Hospital Service, Messrs. M. Burley and M. L. Brenchley, Consultant Orthodontists, and Messrs. P. H. D. Lewars, T. C. Crewe and A. S. Davies, Consultant Oral Surgeons, gave generously of their advice and treated those patients in need of specialist care. We remain indebted to all for their willing and kind assistance. Other departments and sections of the County staff afforded us their co-operation, and on behalf of the dental staff, I extend sincere thanks to the teaching staff of the County, the technical staff of the Central Repair Depot and, not least of all, to the medical and clerical staff of the Health Department, both in the field and at County Hall.

PART III

COMMUNITY CARE

Nursing Services
Health Education
Ambulance Services
Chiropody

OCCUPATIONAL HEALTH

(a) Medical Examinations

Firemen and Drivers of Heavy Goods Vehicles

(b) Medical Advice to Local Taxation Officer

(c) Occupational Health Services

Clinics for the Elderly

Medical Services A.T.C. and Hostels

Artificial Kidney Machines

Food Hygiene in Homes for the Elderly

COMMUNITY CARE

NURSING SERVICES

Many changes were brought about for the County Nursing Service in 1970/71 both administratively and with work undertaken by field staff.

Management

In October 1969 the "Report of the Working Party on Management Structure in Local Authority Nursing Services" was published, presented by the Department of Health and Social Security, Scottish Home and Health Department and the Welsh Office. The report has become known as the "Mayston" report in appreciation of the Chairman, Mr. E. L. Mayston. In August 1970 circular 13/70 was received from the Department of Health and Social Security which said that the Secretary of State was in general agreement with the report and asked Local Authorities to re-organise their existing nursing structure as a matter of urgency in the light of the Working Party's recommendations and to send an interim report on action taken or planned to the Secretary of State not later than the 31st December, 1970.

The principal recommendation of the Mayston Report was that there should be three levels of management, top, middle and first line. The Working Party felt that the demands on the Community Nursing Service would gradually increase and stressed the importance of good management to ensure good liaison and improved care to patients. A proposed management structure was agreed by the Council and in 1971 approval was received by the Department of Health and Social Security.

The above structure was implemented on 1st July, 1971.

For administrative purposes the County was divided into four areas each area co-terminous with two areas of the Department of Social Services. An Area Nursing Officer was based in Bideford, Sidmouth, Newton Abbot and South Brent.

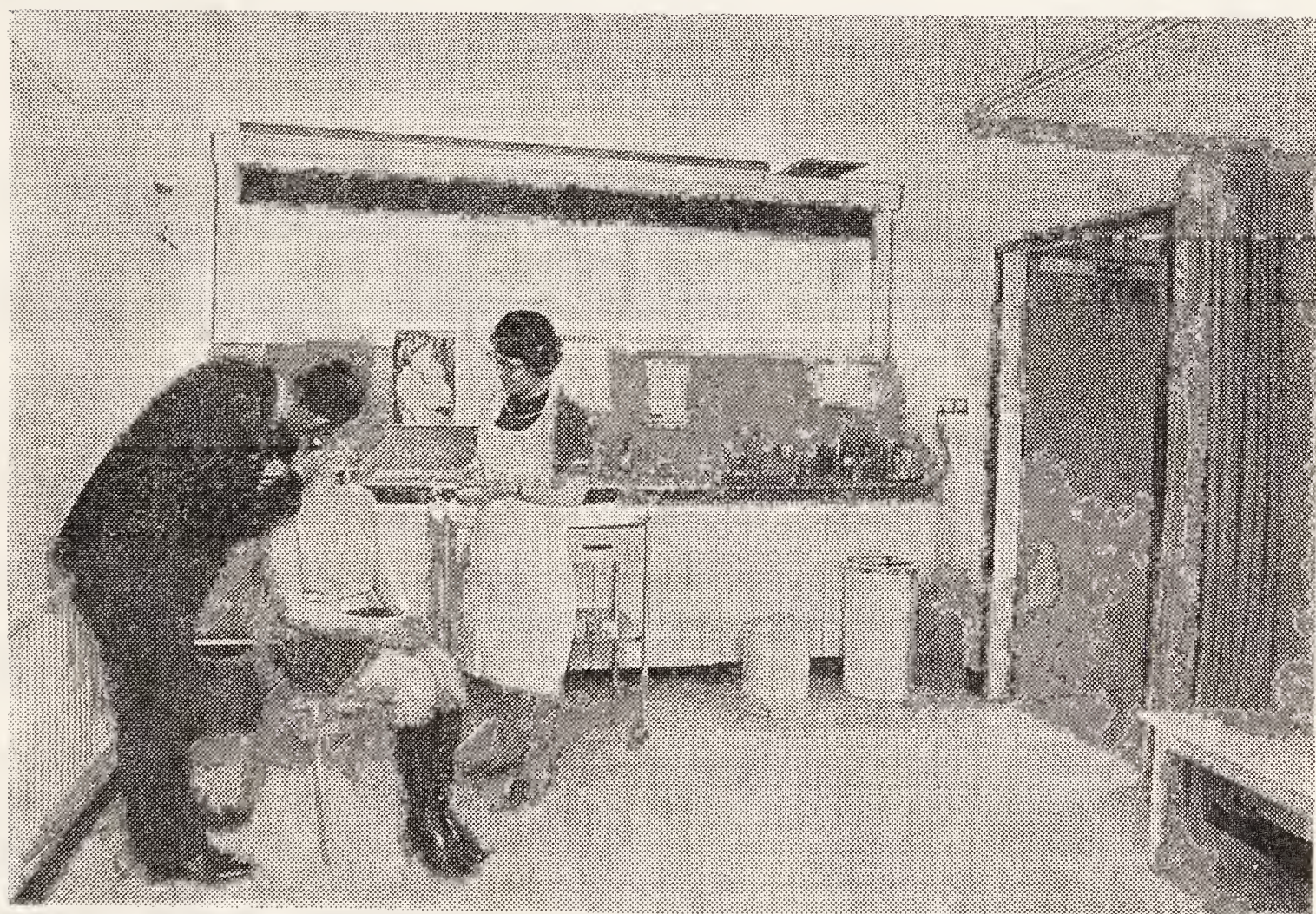
In each area we appointed three nursing officers who are either health visitors or district nurse/midwives with reduced case loads. It is anticipated that their work will soon be purely administrative.

ATTACHMENT TO GROUP MEDICAL PRACTICES

The progress of G.P. attachment was stimulated by the well attended meetings which took place between the C.M.O., Nursing Officers and G.P.'s throughout the County. By the Spring of 1971 we had achieved 100% attachment of Community Nursing Staff to group medical practice. This policy is working well in almost all practices. Attachment means that the staff no longer work in a stipulated geographical area but carry out their duties in attending patients registered with the doctors to whom they are attached.

To make these changes realistic arrangements have been made with Cornwall, Somerset and Exeter City to allow staff to cross geographical boundaries in order to attend patients registered with their practice. Arrangements have been made to commence this "Cross Border Visiting" with Torbay County Borough on 1st April, 1972.

All these changes are resulting in improved team work and a substantial increase in the number of patients attended by all C.N. Staff.



Medical examinations in treatment room by general practitioner with attached district nurse,

THE CHANGING ROLE OF COMMUNITY NURSING STAFF

The Health Visitor

The health visitor is a valued member of the health team. Since attachment many G.P.'s and nursing colleagues have a better understanding and appreciation of her role.

The methods used by health visitors include counselling, supportive therapy, observation to detect early signs of physical and mental defects, health screening and health education.

She is in a position to co-ordinate the advice given by herself and others ensuring that duplication of work is avoided and all needs are covered.

The Clinic Nurse

Whilst continuing to assist the health visitor with routine school work, the field of the clinic nurse has extended to include family planning, cervical cytology, retirement clinics and follow-up visits to the elderly.

The Attached School Nurse

It is now our policy to attach whenever possible a trained nurse to large comprehensive schools. Her responsibilities include counselling and health teaching along with the routine and emergency school health work. It is apparent that having a nurse based in these schools has fulfilled a great need and we hope to be able to extend this service in the future.

The Community Nursing Sister

Although the great proportion of the District Nursing Sister's work is still carried out in the patient's home, the pattern of her work has expanded and developed. Patients are now encouraged to attend nursing treatment sessions in Health Centres and Surgery, where the clinical facilities and equipment are available to meet the current needs of the expanding service.

The Nursing Auxiliary

Nursing Auxiliaries are now being employed mainly in urban areas to assist the Community Nursing Sister with bathing and supervision of the elderly. Their work is much appreciated and these ladies have proved they have an important place in the future Community Nursing Service and are greatly in demand.

The Community Midwife

The number of domiciliary confinements continues to drop but early transfers from maternity units has continued to increase.

In most practices the midwife holds a joint pre-natal clinic with her general practitioner and parentcraft classes with the health visitor.

She is now responsible for the care of all expectant mothers regardless of where confinement will take place.

Arrangements have been made with a number of local maternity units for the Community Midwives to book and to deliver pre-selected cases, taking the mother and baby home again shortly after delivery. This ensures maximum continuity of care and enables the midwife to retain her delivery expertise. Plans have been made for all midwives having few deliveries to gain practical experience in the labour wards of local consultant units.

TRAINING GIVEN TO OUR COMMUNITY NURSING STAFF

District Nursing Training

During 1970/71 36 Community Nurses in Devon obtained their National Certificate of District Nursing.

Training took place at Exeter or Plymouth on a day release basis with practical training being given by our own Senior Nursing Staff. All who sat for the examination were successful.

All new staff will receive this post-certificate training.

Practical Work Instructors' Course

A two-day course was held at County Hall for experienced Community Nursing Sisters to receive instruction in the art of conducting the practical part of District Nursing Training. They were joined by colleagues from Exeter City and Torbay.

Paediatric Developmental Assessment

During 1971 all Health Visitors have attended a day of lectures/demonstrations on developmental assessments of the children under the age of five years. This enables Health Visitors to undertake routine screening of all the children in their care so that minor deviations from the normal are detected early.

Family Planning Training

Six nurses were seconded to the F.P.A. for training to work in the Local Authority F.P. Clinics. Arrangements have been made for 20 more to receive training early in 1972.

During 1971 some of our Health Visitors were pleased to join colleagues from Exeter City at an appreciation course arranged by the F.P.A. Similar courses are being arranged throughout the County.

Management Courses

Two Area Nursing Officers attended Middle Management Courses during 1971. A further Middle Management Course has been arranged for 1972 when all Area Nursing Officers will have completed their management courses.

Two Nursing Officers attended First Line Management Courses in 1971, and two more will be attending in 1972.

Refresher Courses

We continue to send Community Nursing Staff on appropriate refresher courses every five years.

Health Visitor Training

We continue to sponsor 12 students for Health Visitor training each year without obligation.

TRAINING PARTICIPATION BY OUR COMMUNITY NURSING STAFF

Health Visitor Training

Two student Health Visitors from Plymouth are placed with each field work instructor during their training.

The demand from many training centres continues for Health Visitor students to receive supervised practise and rural experience in Devon.

Student Nurses

The North Devon Infirmary has been seconding second year student nurses for a six weeks course in Community care.

A pilot scheme has just been approved by the G.N.C. for a ten week course in community care for students taking training in nursing the mentally sub-normal at the Royal Western Counties Hospital.

Hospital Training Schools continue to send student and pupil nurses for short periods of observation.

Post-Graduate Students

We are always pleased to welcome our medical and nursing colleagues from home and abroad who are undertaking various training and research programmes.

A Royal College of Midwives Refresher Course is held annually in Exeter when midwives spend a day with the Community Nursing Staff.

A number of lectures have been given by senior nursing staff to management courses, refresher and training courses of all disciplines.

RESEARCH

1. *“British Births” Devon Survey*
2. *Home Confinements in Devon*
3. *Nursing Auxiliaries*

During 1970 the above research programmes were carried out in Devon. Assistance with outside research programmes carried out by the Institute of Biometry, Exeter University, together with other organisations and individuals, is always readily given.

LIAISON

With unification of the Health Service in 1974, it is more important now than ever before that all those who are concerned with the health and welfare of the community should work in unison. The County Nursing staff during the past two years have put much effort into getting to know their colleagues in other spheres. As a result the following arrangements have been made:

Liaison with Social Services Department

The co-terminous boundaries of the Health and Social Services areas facilitate closer liaison between the two services. This is necessary to prevent overlapping of services and promote understanding of the needs to be met and where the responsibility lies to meet the need.

Regular meetings occur between the Area Nursing Officers and Area Directors from which all field staff are kept informed of policies and progress made in both departments.

Joint meetings are arranged and invitations are extended from one department to the other to attend meetings, and study periods of mutual interest.

Play Groups

Although responsibility for registration of play groups was passed to the Department of Social Services on 1st April 1971, health visitors have continued to play their role of advice and support.

Hospitals

There has been regular interchange of hospital and community staff at meetings on local level especially in the geriatric, paediatric and maternity fields. These are proving so valuable that it is anticipated they will develop further.

Staff Luncheon Clubs

These have been organised by the Nursing Officers and are now being held regularly in various areas throughout the county. Field staff of all disciplines and members of voluntary agencies attend. The luncheon club provides an informal atmosphere where all can join in free discussion. These are proving most popular.

Working Parties

The community nursing staff are playing an important part along with their medical and nursing colleagues in participating in the many working parties sitting at the present time.

CONCLUSION

The Community Nursing staff have had to face and accept many changes during the last two years, often after long periods of traditional service. I should like to take this opportunity of thanking all my nursing staff for their co-operation and support.

Maternity Services

In the county 5,951 births were notified in 1970 and 5,968 in 1971. Details of domiciliary and institutional births, adjusted for transfers in and out, are set out below:

							1970	1971
Domiciliary	...	...	...	...	...	...	683	460
Institutional	...	...	...	...	...	...	5,268	5,508

92% of all births in 1971 took place in hospitals or maternity units. A large proportion of these cases were transferred early to the care of the district midwives.

Ante-natal Classes

There are 40 ante-natal classes where health visitors and midwives teach relaxation and parentcraft. In some parts of the county evening classes have been arranged in order that interested fathers-to-be can attend. 2,200 representing about 40% of expectant mothers in the county, made 9,150 attendances at these classes. Attendances are high during the first pregnancy but few seem to recognise the need for refresher courses in subsequent pregnancies. Unfortunately many pregnancies continue to come to our notice too late for the mother to obtain the full benefit of this important teaching.

Future ante-natal education will need to include more information on family planning, with facilities for discussion with both wives and husbands.

Family Planning

Close liaison with the Family Planning Association has continued during the period of this report. The Family Planning Association has continued to have the free use of county council premises and in 1971 an increased grant was made to allow for free consultations and supplies for patients seeking advice on medical grounds.

In October, 1970, the first county council family planning centre was established at Holsworthy, followed in 1971 by further centres at Cullompton, Kingsbridge, Sidmouth and Tavistock. The centres at Sidmouth and Tavistock commenced with two sessions in each month. At the other three centres, all of which started with a once monthly session, it soon became apparent that additional sessions were necessary to cope with the demand for the service and an additional session is now being held at these centres each month.

Cervical Cytology

It would seem that far too small a proportion of the eligible women avail themselves of the facilities for the cervical smear test, and the additional check examinations which can be done at the same time. It is clear that special efforts are necessary to encourage women to attend for this purpose either at a local authority clinic or alternatively at the family doctor's surgery. Experience has shown that concentrated drives in specific areas of need produce good results. The Health Department has continued to give every assistance to general practitioners who wish to carry out surveys in the area of their practices.

The nine positive or suspicious cases of cancer found during 1970 and 1971 afford good justification for this type of clinic, quite apart from the various other conditions that are found for which treatment is arranged through the family doctors. During these years 6,188 women attended the local authority cervical cytology clinics making a total of 23,868 attendances since the service was first provided in 1965. In mid-1970 arrangements were made to offer recall appointments to women who had had a previous smear taken at the local authority clinics four years or more earlier. There has been a good response to this recall service.

Dental Care of Expectant and Nursing Mothers

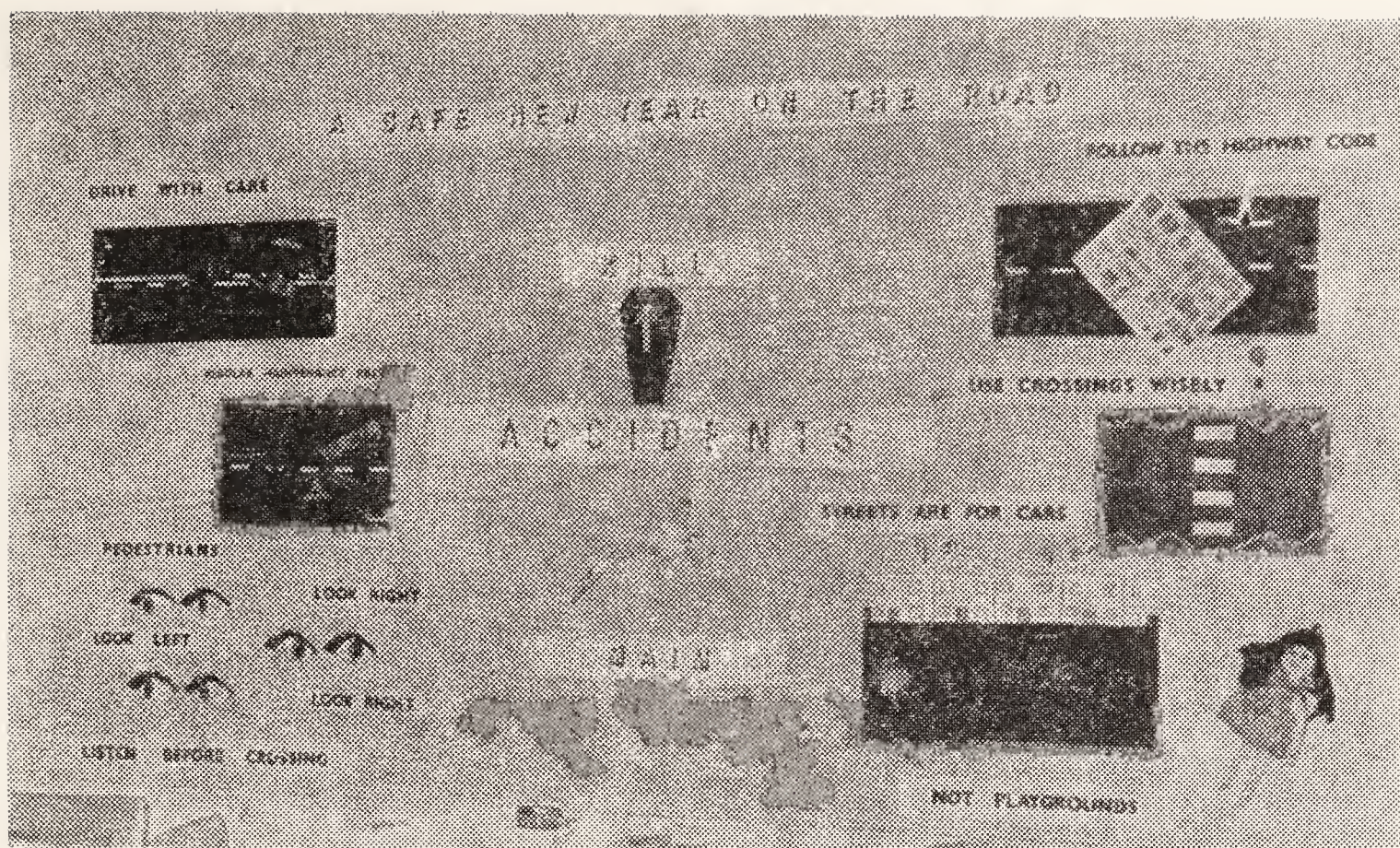
Expectant and nursing mothers are treated in County clinics "on demand", and health visitors and midwives also refer any case found to be in need of dental treatment. The number of mothers treated each year remains low, and it is assumed that most mothers seek treatment through the general dental practitioner service.

The "dental health" session which was a feature of ante-natal relaxation classes was curtailed with the loss of the dental hygienist and the dental auxiliary in 1971, but health visitors are assisting by covering this important topic until replacement dental ancillary staff can be appointed.

HEALTH EDUCATION

The health education section functions as:

1. A support of the field staff of the health department.
2. A direct health education service to various groups.
3. An advisory and consultative service to anyone in the county, whether employed by the local authority or otherwise, provided they have a contribution to make to the health education of the general public.
4. Innovator of new techniques and material.
5. A research team.



Road Safety Display—Ashburton Health Centre
Photo by courtesy of Devon and Cornwall Constabulary

1. As Support of the Field Staff

The section was without a health education officer from 30th January to 31st August, 1971, but even though some areas of health education were adversely affected the film bookings made by the Technical Assistant rose steadily and, at the end of 1971, reached the highest ever peak of 948. The innovation of a film preview scheme (in September 1971) for all medical and para-medical staff has possibly given rise to the notable increase in the use of cine films and a reduction in the number of film strips and cassette loops.

During the years 1970/71 the following audio visual aids were loaned:

	1970	1971
16 mm Cine Films	830	948
35 mm Film Strips Slides	591	399
8 mm Cassettes	493	395

In addition to posters and leaflets supplied to all field staff, especially health visitors, assistance was given and material supplied for creation of displays (see illustration).

The Audio Visual Aid Library comprises: 63 Cine Films, all of which are not currently in use. Eight new ones were added in 1971.

Film Strips and Slides	...	...	...	...	...	...	223
Flannelgraphs	...	...	...	...	...	...	24
Cassettes	...	...	...	...	...	...	116

The stock of projectors in the county is as follows:

16 mm Sound Projectors	...	...	...	...	...	9
8 mm Projectors	...	...	...	...	...	9
35 mm Silent Projectors	...	...	...	...	...	39

The number of 35 mm Projectors increases as the health centres are opened.

Library. During the past two years there has been an ever increasing demand on the facilities offered by the section's library. (The stock consists of approximately 1,200 books, including Acts, Reports, etc.) Whilst many of the older volumes prove invaluable reference works, the continual addition of new

books covering current day problems, e.g. drugs, cancer, the ill effects of smoking, all provide helpful information to medical and field staff alike. Full use has been made of Parliamentary Acts and White Papers held for reference use. Medical journals and papers circulated throughout the department provide invaluable help to members of the staff. Frequent additions to the library continue to be made.

2. Direct Health Education

The field staff of the department, i.e. departmental medical officers, health visitors, nursing officers, district nurse/midwives, are the traditional direct health educators.

The health education officer's involvement with schools is mainly one of support for teachers, invariably demonstrating the content and techniques of health education.

In community groups such as women's organisations, old people's clubs, youth clubs, direct health education was only carried out on an ad hoc basis if field staff were not available.

3. Advisory and Consultative Service

This is a function which is developing. The original image of the health education section as being one basically concerned with supplying posters, leaflets and films is changing to one of a group of health educators who are concerned with all the ramifications of health education. Advice extends beyond merely suggesting audio visual aids and takes in such factors as priorities, choice of methods, and the social and psychological implications of the projects. The advice given is based on a set of sound principles which aim at removing the hit and miss approach which has characterised so many attempts at health education. Requests for advice came from various people, among them:

- Health Visitors;
- Doctors;
- Teachers;
- Students;
- Voluntary Organisations.

4. Health Education Innovators

One of the basic requirements for carrying out this function is to have as wide a range of contact as possible, and in recent years these contacts have included the police, educators at all levels, youth leaders, marriage guidance counsellors, doctors and social workers.

5. As a Research Team

As a comparatively new discipline, health education has yet to find a way of developing itself in a scientific manner. It has been very much governed by the intuition of its practitioners and patterns of morbidity and mortality statistics. Consequently there is little objectively recorded information on which intended projects could be based. The section has its obligations to research very much in mind, and some of the areas to be covered are:

- Community attitudes to mental health, sex education and the mentally retarded.

- Social education in school—Yes or No?

- Attitudes of primary school children to smoking, etc.

- Cancer education—how effective is it?

Dental Health. In the absence of a dental hygienist the section continues to help out with talks to various groups.

Visitors to the Section. Visitors to the section are encouraged and during the last two years many visitors were welcomed.

Conclusions

1970/71 have seen many changes in the section. Much credit goes to the health education technical assistant and the part-time clerk who, in the absence of a health education officer, carried on the section and effected a move to alternative accommodation. The work continues to grow with far more requests for films and material from field staff and teachers. In the near future we will be on the move again, to more favourable and spacious accommodation where, it is hoped, we will be able to establish a centre and thereby attract more field staff, school teachers and children.

The new health education officer took up her appointment on the 1st September, 1971, and the appointment of an Art assistant was made in October. Changes of policy and of administrative techniques, in response to a developing service, will it is hoped continue to provide an attractive and effective service. We realise that we have a long way to go in achieving our aims, which are "to enable all individuals (young and old, male and female) to lead fuller happier lives and to appreciate the importance of the quality of life". We lack the funds and the manpower at the present time, but we have the spirit, the tenacity and the drive to go forward into another year. We know that to bring about a change in the attitude of the public to health education is a very long term process. This will, I am sure, be the most arduous but potentially the most effective aspect of the work of this section.

DENTAL HEALTH EDUCATION

Dental health education in the County suffered a severe setback when the dental hygienist, Miss Pamela Turnage, emigrated to Australia early in 1971. Miss Turnage had been involved full time in dental health education in Devon since 1965, and her ability and enthusiasm had deservedly won the respect and co-operation of headteachers in primary schools, health visitors in ante-natal classes, and playgroups organisers. Her departure was offset for a time by the employment of Mrs. Jane Nichols, dental auxiliary, who was infected with the same enthusiasm and belief in the benefits of dental health education. Mrs. Nichols' clinical duties confined her sphere of operation in dental health education to South Devon where she too enjoyed the respect and co-operation of headteachers. Her resignation later in the year left a gap in the dental health education field which remains unfilled.

It is undoubtedly true that teachers can play a vital role in influencing the attitude of schoolchildren to dental health. It is equally true that they welcome guidance and information on the subject, and our dental auxiliaries in Devon have proved their capacity to provide this necessary information and assistance. For this reason alone, it is to be hoped that the vacant ancillary posts will be filled without undue delay.

In 1970, the impetus given to reaching adult audiences was re-inforced with such success that 63 evening visits were made by the Chief Dental Officer or Dental Hygienist, for a film show/discussion session. The groups visited included parent/teacher associations, Womens Institutes and Church groups, and the audiences were composed mainly of parents who can exert a profound influence on the attitudes and habits of their children with regard to personal dental care. In 1971, the practice of dental officers actively encouraging headteachers to arrange an evening visit was suspended, since head teachers had been faced

with this request at least three times in the previous three years and it was considered politic to break the established routine for at least a year. Despite the lack of active stimulation to programme evening meetings, 13 such visits were paid by the Chief Dental Officer or Health Education Officer in 1971. After an appropriate interval, the practice of encouraging evening meetings will be recommenced.

The “apples for schools” scheme which started in 1969, was considerably extended over the next two years as more contractors were found who were willing to supply and deliver apples for re-sale to children in schools. During 1971, 229 schools were offered the opportunity to join the scheme and 112 of these schools actively participated. The scheme is designed to offer children an acceptable alternative within the school, to the sweet biscuits and confectionery which are so damaging to teeth. Even in schools where no cariogenic food in the form of between-meal snacks is sold or consumed, the example set within the school of encouraging children to eat apples will have a dental benefit in the long term, if it results in a reduction in the consumption by children of sweet (and usually sticky) carbohydrates between meals. Perhaps surprisingly in a county renowned for its cider production, Devon has a comparatively small acreage of commercially grown dessert apples. In those areas where suitable apples are grown locally, some headteachers obtain supplies direct. In most of the County, it is difficult to interest contractors in the “apples for schools” scheme since apples must be brought in from other parts of the country and then delivered regularly, often in small quantities, to schools in rural areas. To date, six contractors are supplying apples to schools and the scheme will be extended as the opportunity to cover new areas of the County are presented.

AMBULANCE SERVICE

The major event during this period has been the transfer of the full-time staff from the voluntary agencies to the employment of the County Council. This transition was carried out very smoothly indeed and thanks are due to the voluntary associations and to the full-time staff for the ease with which the operation proceeded. The full-time staff through their consultative committee agreed that the transfer would not in any way affect the good relations which existed with the voluntary aid societies and the volunteers.

Whilst the voluntary effort still continues there is no doubt that the number who are able and willing to serve on the ambulances is declining. This has resulted in the need to appoint several additional full-time drivers during the two years.

Training

The training programme has been kept completely up to date. All new staff are given a fortnight's induction course followed by the six-weeks course at the Southern Ambulance Training School and one week's training inside their local hospital. Existing staff are being given local courses and a fortnight's refresher course at the Southern Ambulance Training School every three years. I am very pleased to report the success of the training carried out in hospitals. All the full-time staff have undertaken this and some are now entering on their second hospital training period. I cannot speak too highly of the co-operation received from the staff at the hospitals, who have gone out of their way not only to give the crews the training they need but also to make them welcome and make them feel part of the team.

Training has also been given in the use of rescue equipment for extricating casualties who are trapped, in the use of spinal boards, and in the use of Entonox which has been introduced into the Ambulance Service. Entonox has been welcomed by patients and crews who previously had to stand by rather help-

lessly whilst patients suffered pain. All the full-time staff have been given driving instruction.

We continue to second our officers to the Southern Ambulance Training School as Instructors. This I feel is of advantage to our officers and allows the Southern Ambulance Training School to have the benefit of another ambulance service's views from officers who are in operational touch with day to day ambulance affairs.

Five members of the ambulance staff have qualified as Fellows of the Institute of Certificated Ambulance personnal and five as Graduates of the Institute of Ambulance officers. In the latter examination Mr. Jelfs of Exmouth and Mr. Stuckey of Tiverton passed with distinction. Mr. Jelfs was placed first in the United Kingdom.

Ambulance Service Consultative Committee

An ambulance service consultative committee has been set up on informal lines following the recommendations of the McCarthy report. This has been welcomed by the men and has proved very useful in discussing problems concerning their working conditions and the improvement of ambulance equipment.

The Hospital Service

Our links with the hospitals have been strengthened by the training given to the ambulancemen in hospitals. A good spirit of team work has been built up between the ambulance crews and the nursing and medical staffs at the hospitals which has undoubtedly led to an improvement in the help we are able to give to casulties and patients on the journey into hospital. There has been some reciprocation in that ambulance officers have visited hospitals to lecture to nurses training courses on the work of the ambulance service and how they can help to ensure the proper use of the ambulance service. The county ambulance officer attends meetings with the administrative staff of all the main hospitals at regular intervals to discuss the co-ordination and co-operation of their services.

Ambulance Service Advisory Committee

I am very pleased to report that Mr. R. P. Selley, the County Ambulance Officer, has been made a member of this committee which advises the Secretary of State on ambulance affairs.

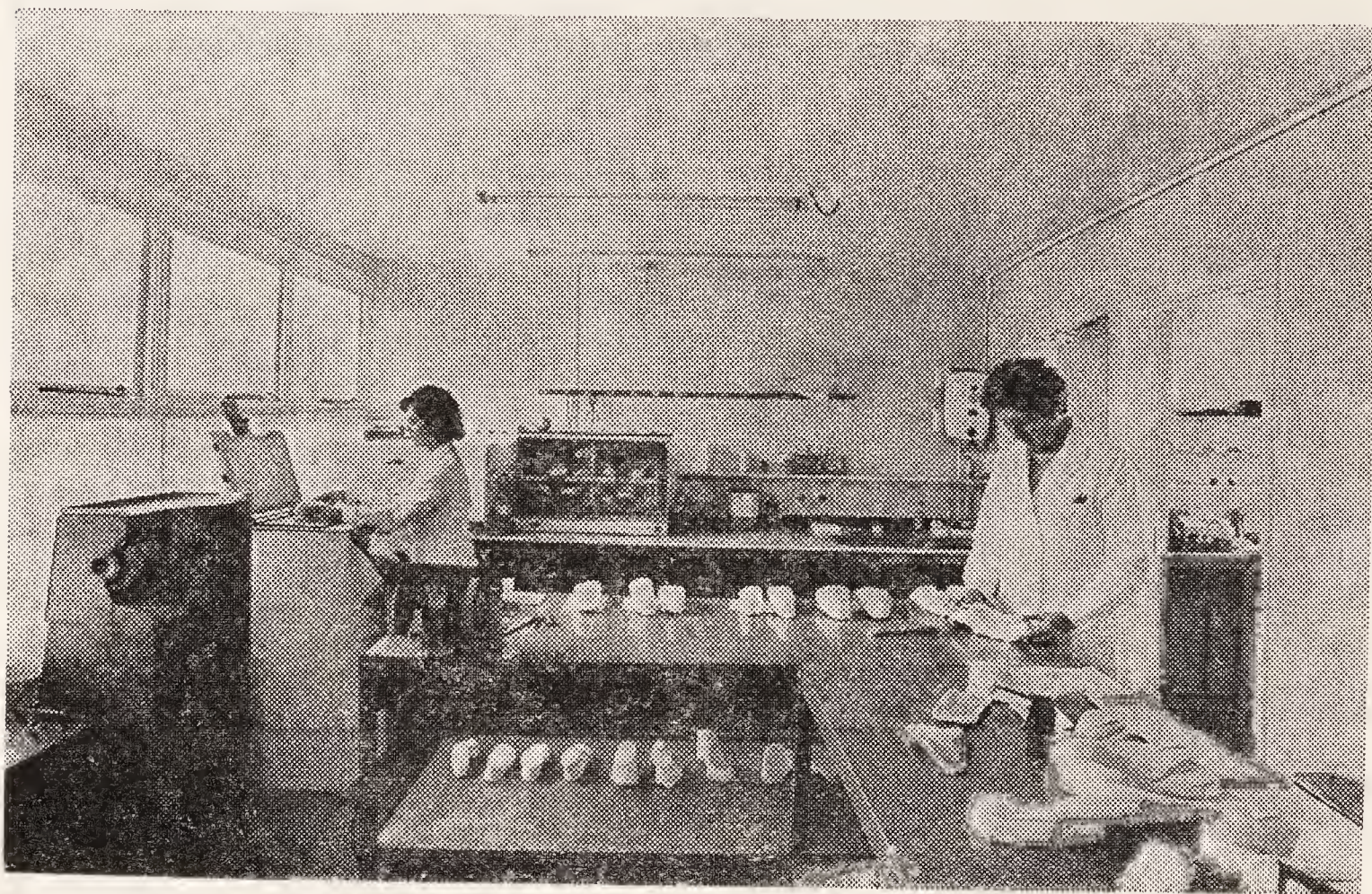
TABLE SHOWING PATIENTS CARRIED BY THE DEVON AMBULANCE SERVICE
FOR THE YEARS ENDING

	1970	1971
<i>Ambulances</i>		
Patients	69,632	69,800
Emergencies	7,410	7,644
Mileage	829,716	885,013
<i>Hospital Car Service</i>		
Patients	335,573	335,387
Mileage	3,031,709	3,112,786
<i>Hired Cars</i>		
Patients	12,987	12,442
Mileage	57,087	50,580
<i>Totals</i>		
Patients	418,192	417,629
Mileage	3,918,512	4,048,379

CHIROPODY

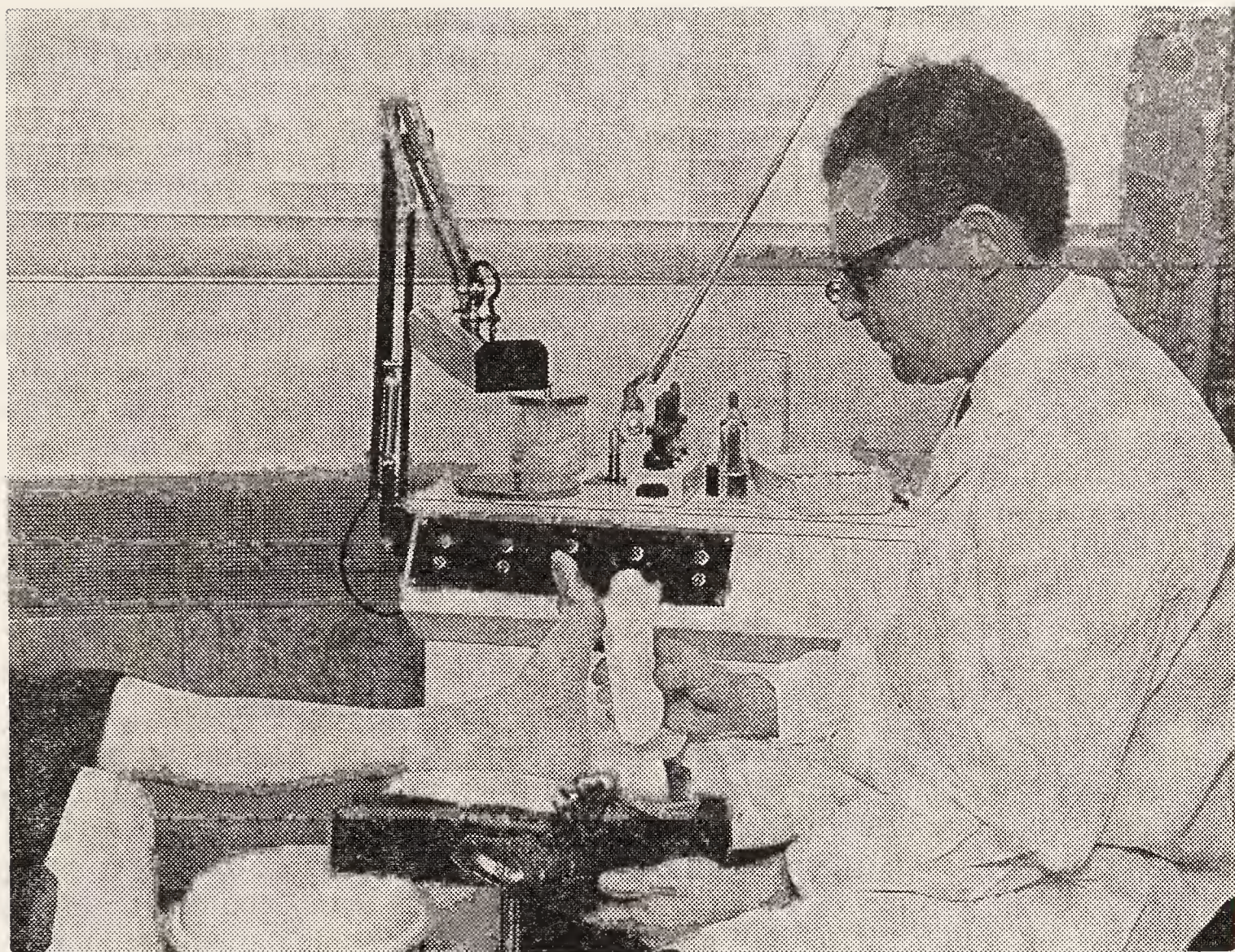
This service is available to four groups in the community—the handicapped, expectant mothers, school-children and old people: the last group accounting for about 98% of the treatments given. Many foot troubles are the result of lack of care of the feet in early life and the ingrained bad habits of a lifetime; and in the case of some women a legacy of the dictates of past shoe fashions. There is no doubt however that the chiropody service is particularly appreciated by the older members of the community.

When the chiropody service started in the county the lowest age limit for old people was 60 years. Recently the Department of Health and Social Security suggested that the lowest age should be 65. Very few men below this age apply for or receive treatment and the committee then decided that, whilst women of 60 years of age should continue to receive treatment, no new male patients under 65 should be accepted. This has, to a very slight extent, slowed the growth of the list of patients awaiting treatment.



Main appliance room, where all Insoles are made by vacuum forming. Operator is placing cast in position ready for forming whilst other is checking for accurate fit after trimming appliance.

With the introduction recently of the Handicapped & Disabled Persons Act the range of disabled and handicapped persons eligible for treatment has broadened to include not only persons registered as handicapped but also those persons below the age of 65 who are eligible for inclusion in such a register but are not in fact so registered. However, as this authority has always erred on the side of generosity in this respect, this has not increased to any great extent the number of handicapped persons treated, except that some old persons under 65 who were formerly receiving treatment because they were over 60 now receive treatment as handicapped persons. The Registrar-General has ruled that if a person falls into another treatment category besides handicapped, e.g. handicapped and pregnant, statistically speaking she should be regarded as handicapped only. This authority does however require that a handicapped person's application for chiropody treatment should be certified by his/her doctor.



Completed appliance returned to Chiropodist and being fitted to the patient.

Demands on the service continue to grow each year and, although in the two years ending December 1971 the establishment of chiropodists has increased (by one) to 20, and the establishment of chiropody technicians increased to two, the waiting list has grown. This has been due to several factors, not the least being the failure to attract new staff to fill vacancies. Indeed, at the end of 1970 and the beginning of 1971, there were no less than five vacancies and, although the situation improved later in the year, there were still two vacancies in December 1971, when the waiting list was almost 1,000. The fact that the chiropody laboratory was able to recruit the additional technician required has meant however a growing production of appliances, so that some patients were either discharged or seen at less frequent intervals, which has been of considerable assistance in keeping the waiting list as low as possible. It should also be remembered that Devon is a popular retirement area and that, with the increase of general medical knowledge, people are in the main living longer.

The increase in the number of health centres with adequate chiropody surgery facilities has meant that it has become more economic, from the point of view of the chiropodists' time, to close some of the smaller inadequate rural clinics held in local halls and bring the patients to the new health centres, even if this has meant an increase in the use of the hospital car service where public transport is inadequate or non-existent. The number of patients carried by hospital car for 1970 and 1971 respectively were 9,238 and 9,668 compared with 7,486 in 1969.

On the 31st December, 1969, there were 74 clinics operating, but at the end of 1971, this number had fallen to 69. The justification for this policy will be seen in that in 1969, 49,628 treatments were given at a time when the establishment of chiropodists was high, but two years later, in 1971, when the actual number of chiropodists' sessions was less, 52,706 treatments were given.

Incidentally, 59,230 appointments were made, so that the failure rate was about 11 %: this percentage of failure remains fairly constant over the years although every effort has been made to reduce it.

Two other factors increase the demand for chiropody in an area, the appointment of a new chiropodist and the opening of a new health centre. An illustration of the first is the Ilfracombe area, which was without a chiropodist for nine months: when a new chiropodist took up his appointment he inherited a normal clinic case-load and a waiting list of 140. By natural termination of need and the concentration of treatments in health centres he was able in the space of a few months to reduce the waiting list to about a dozen, but immediately this happened more and more persons applied for treatment and, within six months, the waiting list was about 50. Examples of the effect of opening a new health centre are Chagford, Moretonhampstead and Chudleigh. Previously clinics had been held once monthly at the first two places and, during 1970, it was possible to reduce the time spent at Chudleigh from every Thursday to thrice monthly, due to the lack of demand. However, as soon as health centres were opened in these three towns, there was a large increase in applications for treatment and it has been necessary to consider ways to increase the time spent at all three centres to cope with the greatly increased demand.

The main objective of the service is to keep as many persons as possible (particularly the elderly) mobile and active in their own homes instead of allowing them to become housebound and eventually in need of residential care by the social services department or in a geriatric ward. That this objective is being reached is evident by the fact that some domiciliary patients become fit enough to attend a clinic and resume outdoor activity and that some patients no longer require hospital cars to be taken to a clinic for treatment. Some patients are discharged after a few months' treatment, including possibly the provision of an appliance made at the chiropody laboratory.

	1967	1968	1969	1970	1971
Number of chiropody clinics operating ...	122	98	74	72	69
Old Peoples Homes and Hostels visited (Private and D.C.C.)	29	24	25	26	28
Treatment at D.C.C. Hostels for Elderly	2,907	2,653	2,878	2,890	3,336
Treatment at Registered Homes for Elderly	806	667	323	335	326
Treatments to schoolchildren	1,598	913	643	372	1,314
Treatments to adults at clinics	50,467	42,309	43,826	42,210	46,703
Domiciliary treatments provided	998	314	713	422	1,027
Total treatments provided	56,776	46,856	48,383	46,229	52,706
Waiting list at 31st December	802	660	481	*970	975
Chiropodial appliances fitted	595	649	2,659	1,611	2,649

* Due to five vacancies this figure is arbitrary but would not have been much less and in any case does not include patients on the books but receiving no treatment.

THE CHIROPODY LABORATORY

The demand for this service has increased over the past year. This is undoubtedly due to the popularity of Plastazote appliances. During the past six months a much easier way of providing sandal type footwear has been developed for patients who are unable, for one reason or another, to wear the conventional type of footwear and are unable to make use of orthopaedic shoes. The manufacture of this new type of appliance, which is so light and pleasing to the patient, is now being undertaken by other authorities, and continual experiments are taking place to improve this footwear even further. Without the

laboratory the increasing demand for chiropody could not have been as well met, unless there had been a big increase in the number of chiropodists employed. The laboratory is staffed by one full-time and two part-time technicians working under the control of the Chief Chiropody Officer. During the years 1971/72, 2,030 insoles and special appliances and 2,050 Latex appliances have been made for patients in the county.

This chiropody laboratory has promoted great interest throughout the country and has been visited by medical officers and chiropodists from many other local authorities eager to learn our techniques and organisation. The Chief Chiropody Officer has also been asked to give talks to several groups of medical officers and chiropodists of other local authorities.

OCCUPATIONAL HEALTH

MEDICAL EXAMINATION OF FIREMEN

Standards of medical examination used to vary greatly throughout the country. In some places there was no formal medical examination and in others a lengthy and detailed examination was undertaken with very strict standards.

The Home Office, which is the government department responsible, appointed a committee to review the medical standards for Fire Services. This committee made several recommendations regarding the medical standards of firemen who, they said, should be examined on entry to the Fire Service, at the age of 40, and every three years thereafter until retirement. These standards were designed to try to ensure that the fireman's health was such that he would be no danger to himself, his colleagues, or the public, whilst he was on duty.

The committee's report gave a great deal of guidance together with a suggested list of conditions which would render a man unfit for Fire Service duties. It revised the standards for visual acuity which, in the past, had been different for retained and fulltime firemen, and suggested that a common standard should be adopted. The committee also made recommendations that a standard form of reporting should be used in these medicals to ensure uniformity throughout the country.

Since 1961 the Joint Devon & Torbay Fire Service has required recruits to be medically examined. The medical standard for entry for the retained men was somewhat lower than that for the full-timers. In late 1970 the Devon & Torbay Joint Fire Committee accepted the standards which had recently been proposed by the Home Office and these have operated since April 1971.

It was thought desirable both by the Home Office and the Fire Brigade Unions that one medical officer should cover the whole of Devon in order to achieve consistent medical standards. It was expected that this medical officer would become familiar with the duties undertaken by firemen. A senior medical officer, Dr. J. A. Theobald, has been designated Brigade Medical Officer, to be responsible for both administration of the scheme and the medical examinations.

Since April 1971, when the scheme began, firemen have been examined by Dr. Theobald at six centres in the county, i.e. Barnstaple, Newton Abbot, Ashburton, Dawlish, Okehampton and County Hall. These examinations will continue over a period of three years, by which time the men will be due for re-examination.

In a small proportion of cases it has been necessary to examine firemen more frequently than once in three years. If an abnormality is found which might respond to treatment then, with the fireman's permission, his general practitioner is informed. Some abnormalities render a man unfit for fire service duty but, in some instances, it may be possible to reconsider a man for normal duties after treatment. Sometimes it is necessary to obtain further medical information from the general practitioner or, even more infrequently, from a hospital consultant. When all the information has been collected, a suitable recommendation is made by the Brigade Medical Officer to the Chief Fire Officer.

MEDICAL EXAMINATION OF APPLICANTS NEEDING HEAVY GOODS VEHICLE DRIVING LICENCES—

In February 1969 new regulations came into force for the issue of driving licences to drivers of commercial vehicles of over three tons in weight. These regulations require the applicant for a heavy goods vehicle driver's licence to produce with his application form a completed statutory certificate of fitness to drive, after examination by a registered medical practitioner. The county council has approximately 700 men who need licences to drive such vehicles and who would in due course on licence renewal require to be medically examined.

In order to achieve administrative and medical co-ordination it was felt that one senior medical officer should administer the scheme and also medically examine the applicants. Dr. J. A. Theobald has examined 400 men so far in the 23 months since the regulations came into force.

Firemen require heavy goods vehicle licences in order to drive their fire engines and 230 firemen drivers have been examined in the same period. For all the drivers the same six centres have been used as for the medical examination of recruits and over-40-year-old firemen mentioned previously.

MEDICAL ADVICE TO THE LOCAL TAXATION OFFICER

The Local Taxation Officer is responsible, on behalf of the Secretary of State for the Environment, for issuing driving licences to eligible members of the public.

The revised driving licence application form requires answers to several questions relating to health. Whilst some of the answers are straight forward many others are not, and the Local Taxation Officer often requires medical advice before issuing a driving licence, in order to decide whether the person applying is in fact fit to drive or whether their licence should be modified in some way after a special driving test.

For several years past Dr. J. A. Theobald has been making medical enquiries and advising the Local Taxation committee on my behalf. No accurate records have been kept of numbers of enquiries made, but about 300 new enquiries have been made each year, together with many other follow-up enquiries.

Since the introduction recently of the new driving licence application form and the new regulations regarding epilepsy and driving, the number of enquiries made have increased markedly.

In normal circumstances enquiries are made of the general practitioner, after obtaining the consent of the applicant. Medical facts rather than opinions are asked for and, from this information, a recommendation is made to the Local Taxation Officer and the Taxation Committee. In some cases it may be necessary for information or advice to be obtained from a hospital consultant, or for the applicant to be medically examined.

OCCUPATIONAL HEALTH SERVICE

For many years past I have, through one or other of my medical officers, made medical enquiries about the fitness of staff of all county council departments for their particular post, and have made recommendations to the appropriate chief officer. These enquiries have been made either before appointment or when the employee became sick and was away for a long period.

Early in July 1971 a meeting of chief officers expressed concern over the number of senior staff with a poor sickness record. Investigation had shown that about 7% of the professional and administrative staff of the county council had been absent through sickness for periods exceeding 25 working days over the preceding three years. Premature retirements, although not numerous, were mainly accounted for by the various complications of cardio-vascular degeneration. It was felt that earlier diagnosis and treatment of some of the cases would have given them a longer and more active life. The second largest cause of early retirement was mental illness and it was felt that an occupational health service might elicit premonitory symptoms and, by early advice, reduce the degree of invalidism.

The question of such a service had been previously discussed in the health department and it was felt that an offer of a fairly comprehensive medical check should be made to staff. Such an examination by a doctor would take place after the member of staff had filled in a health questionnaire and had undergone certain simple tests made by a nurse. Naturally the information obtained would be entirely confidential and would not be disclosed to any third person (including the employing department) without the employee's consent. Any disease or abnormality needing treatment would of course be referred to the patient's own general practitioner, after the patient's permission had been obtained.

Such a scheme was accepted by the county council in July 1971 initially to cover those aged 40–50 years working in or near County Hall. The scheme was to be extended as time went on and would very quickly include a certain amount of group health education. Dr. J. A. Theobald was then designated staff medical officer and also became responsible for all other types of staff medical enquiry and examination.

At the end of the period covered by this report plans were well advanced for the scheme to commence. Examination facilities were nearly completed and about three-quarters of the staff eligible for medical examination had indicated in a questionnaire their wish to be examined.

CLINICS FOR THE ELDERLY

These clinics, which were originally started as a pilot scheme in 1968, continued as they had proved to be most useful. New clinics started, and others ceased operation for various reasons and, at the end of the period covered by this report the elderly were being screened at six clinics.

As noted in previous annual reports most of the conditions discovered by these examinations, although not serious, nevertheless handicapped the patient to some extent. Many people accept poor hearing and poor sight as they age, and therefore tend not to seek the remedies that are available. This holds true for many other conditions which render the patient much less socially able than he or she could be.



Using the Wright peak flow meter.

Further analysis of the reports has confirmed previous findings and has strengthened the evidence that anaemia amongst the aged is certainly of no major significance in those old people so far examined in Devon. This is, of course, a small selected group and so it cannot be assumed that the same is necessarily true for other parts of the country, or even other parts of Devon.

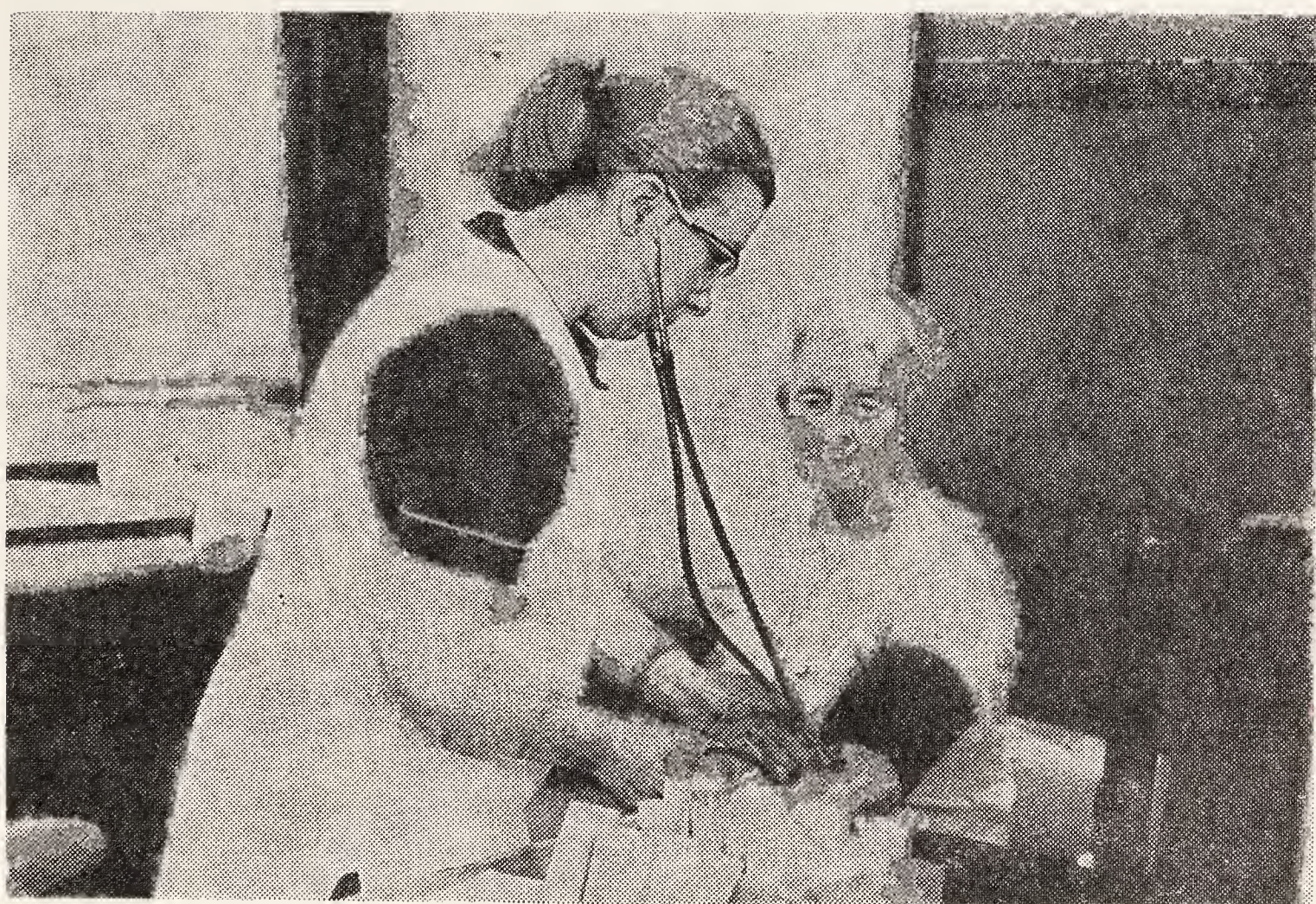
A large number of apparently fit patients complained of coughing and breathlessness, and 20% of both men and women said that they had frequent headaches. Tiredness was complained of by one-third of men and almost a half of the women, and these numbers were roughly similar to those who had complained of sleeping badly. One-third of both men and women were more than 10% overweight.

A third of the men and a quarter of the women had some difficulty in hearing a voice of normal conversational level. Deafness of this degree can, of course, easily lead to social isolation, as can visual defects, which were found in one-in-four of the men and one-in-six of the women.

Many of the conditions found are, as previously mentioned, of relatively minor medical significance. Early in 1971 general practitioners involved in



Taking blood for laboratory test.



Measuring blood pressure.

retirement clinics met consultant geriatricians and pathologists at County Hall. It was decided, after long discussion, that the clinics were valuable and should certainly continue and that the age group covered by these clinics should remain at 65–70 year olds. Comment was made that much of the “treatment” for the conditions found consisted of advice, for example about diet or of referral to dentists, opticians, chiropodists, etc. The general practitioners felt that these referrals could easily be made by the health visitors and nurses in the clinics, and that they should be consulted previously only if a strictly “medical” need was apparent.

As a result of this meeting the procedure for these clinics, although not altered drastically, was nevertheless streamlined so that the health visitor and nurse had much more responsibility than hitherto for screening the patient and deciding the next move. There were, of course, certain criteria laid down as to when the doctor should be consulted; for example, a positive answer to certain questions or groups of questions on the questionnaire, unexplained weight loss or abnormal results on certain blood tests.

This revised procedure has only been in use for a few months but seems to be working smoothly and achieving good results. Over a long period the figures from this new procedure should provide valuable evidence on the health of the elderly in Devon.

Interest in these clinics has been expressed by several other groups of doctors and it is hoped that more of these clinics will be started fairly early in 1972.

ADULT TRAINING CENTRE AND ADULT HOSTEL MEDICAL SERVICES

Before 1st April, 1971, the adult training centres and adult hostels were the responsibility of the health department. There was direct supervision by a medical officer at County Hall, who was also responsible for the day-to-day running of the establishments. Each centre also had its own medical officer, who examined the trainees and gave general medical advice about them to the staffs of the centres.

During 1970 H.M. Factory Inspectorate regarded the adult training centres as factories within the meaning of the current Factories Act. Thus each adult training centre was required to have its own “Appointed Factory Doctor”. The existing medical officers to the adult training centres were accepted by H.M. Factory Inspectorate as being suitable and were appointed officially in January 1971. The appointment in fact entailed little extra work, since the medical officers already examined all new entrants to an adult training centre, and kept medical records, and now had merely to fill in the statutory form for those under 18 years of age.

When the social services department was formed in April 1971, the scheme continued as before and the medical officers continued to exercise general medical supervision in the centres and hostels and the special responsibilities for those under 18 years of age.

The county dental service was able to offer annual inspection and treatment to every adult workshop trainee in 1970 and 1971, with some workshops being covered twice in the year, where staffing permitted. The standard of oral hygiene in these patients is usually low, but regular dental examination followed by treatment where necessary can effect improvement, and the efforts of the staff in the workshops, who encourage adult trainees to accept dental treatment, is greatly appreciated.

ARTIFICIAL KIDNEY MACHINES IN THE HOME

During the two years covered by this report the health department has provided adaptations to homes so that a further 18 artificial kidney machines could be installed. These adaptations were done in liaison with Whipton Hospital, Exeter, Greenbank Hospital, Plymouth, and in one case Southmead Hospital, Bristol. The cost of each adaptation to this authority averaged out at almost £500; lowest costs were where adaptations were made in an existing room, and the highest costs were where a portable building had to be provided and sited in the garden. The decision as to whether a portable building was to be used or not rested on whether there was a suitable room to adapt or whether there was sufficient ground on which to place the portable building. In some ways the portable building has the advantage that it can be moved for use by someone else if the original patient no longer needs it,

No charge is made to the patient for these adaptations and, at the time of adaptation, an agreement is made with the owner to restore the property to its original condition if the artificial kidney machine is no longer required. This would normally only happen if either the patient died or had received a successful kidney transplant.

FOOD HYGIENE IN OLD PEOPLE'S AND PRIVATE REGISTERED HOMES

The new social services department is (and previously the welfare department was) responsible for registration of the various categories of residential homes for the aged, the handicapped, children etc. There are several conditions which have to be satisfied before registration is approved and one of these is compliance with the current food hygiene regulations.

The responsibility for enforcement of the food hygiene regulations rests, of course, with the district medical officers of health. The health department acts for the social services department in notifying the district medical officer of health and asking for a report on food hygiene at a particular home and interpreting the report. A recommendation is then made to the social services department regarding any necessary work which is needed before the required standards are met. Up-to-date lists of registered premises are sent to the district medical officers regularly. Homes etc. which are run by the county council are not strictly covered by the food hygiene regulations, but it is obviously desirable that the food hygiene standards in such establishments should at least reach the standard required for registered homes. Recommendations and standards on these, as well as the nursing homes and mental nursing homes registered with the health department, are co-ordinated by the health department.

PART IV

CAPITAL BUILDING PROGRAMME

CAPITAL BUILDING PROGRAMME

Health Centres

The building programme for the two years covered by this review includes the opening of five new purpose-built centres. These were at Dawlish, Chudleigh, Yelverton, Chagford and Moretonhampstead. They provide consulting room facilities for 14 general practitioners. During this period major adaptations were also completed at South Brent, which now has two consulting rooms as well as adequate base accommodation for local health authority staff.

There are now 75 general practitioners in the county area, with consulting room suites in the 28 health centres that have so far been built. This number will be increased to 100 general practitioners when the five buildings now under construction at Chulmleigh, Silverton, Kingskerswell, Exmouth and Bideford are completed.

The projects that are in the capital building programme to cover the period to 1974 will allow the number of general practitioners with suites in health centres to be increased to 136. This is over 60% of all the general practitioners with surgery accommodation in the county area.

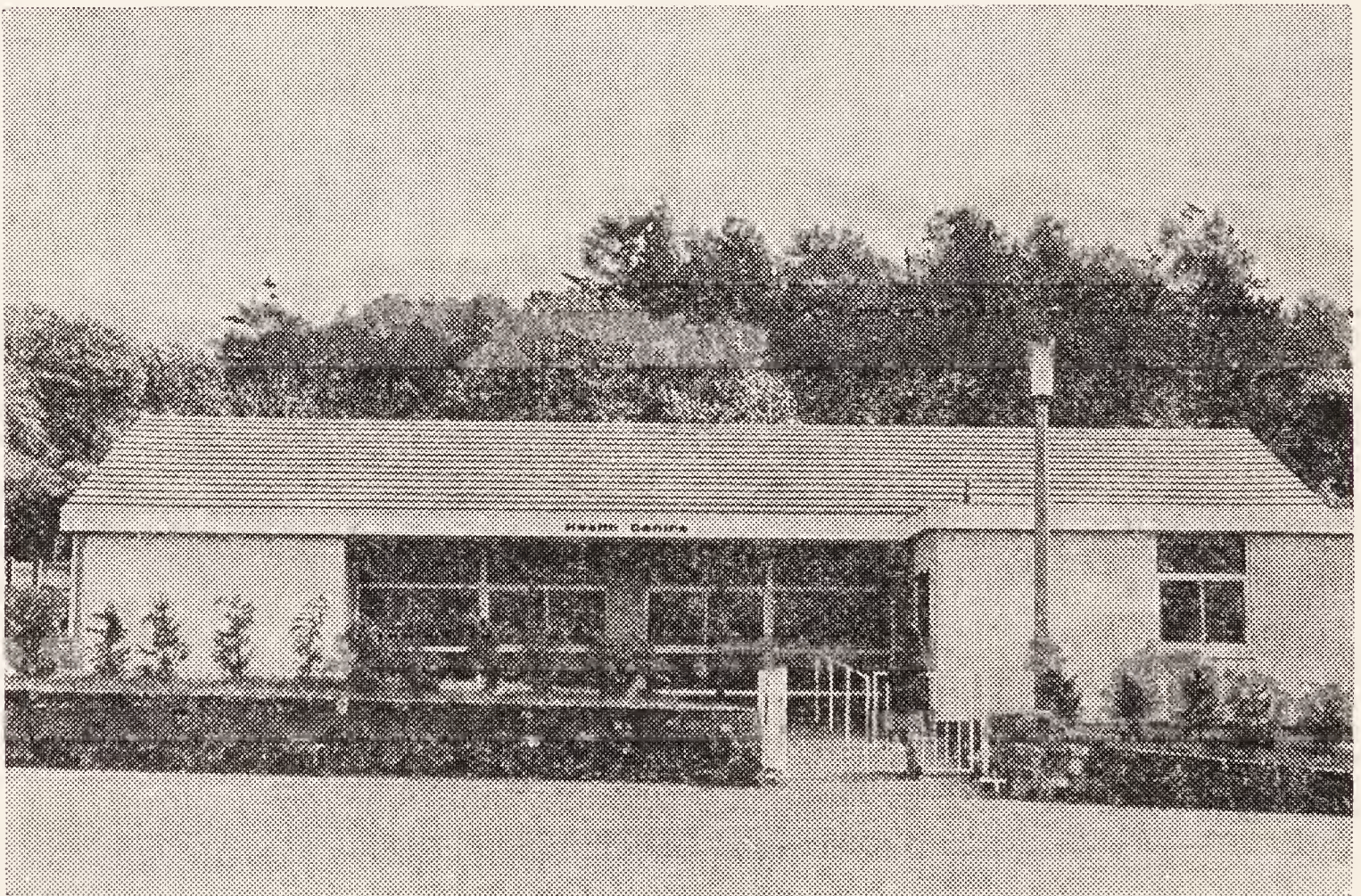
Full details of completed projects, as well as those under construction and planned, are given on page 57.

Ambulance Stations

A new station is under construction at Newton Abbot and is on a shared site with the Fire Service. The Department of Health and Social Security have given their approval to the following projects being included in the capital building programme:

1972/73—Dawlish, Tiverton, Ilfracombe.

1973/74—Honiton, Totnes, Kingsbridge.



Health centre in a rural area.

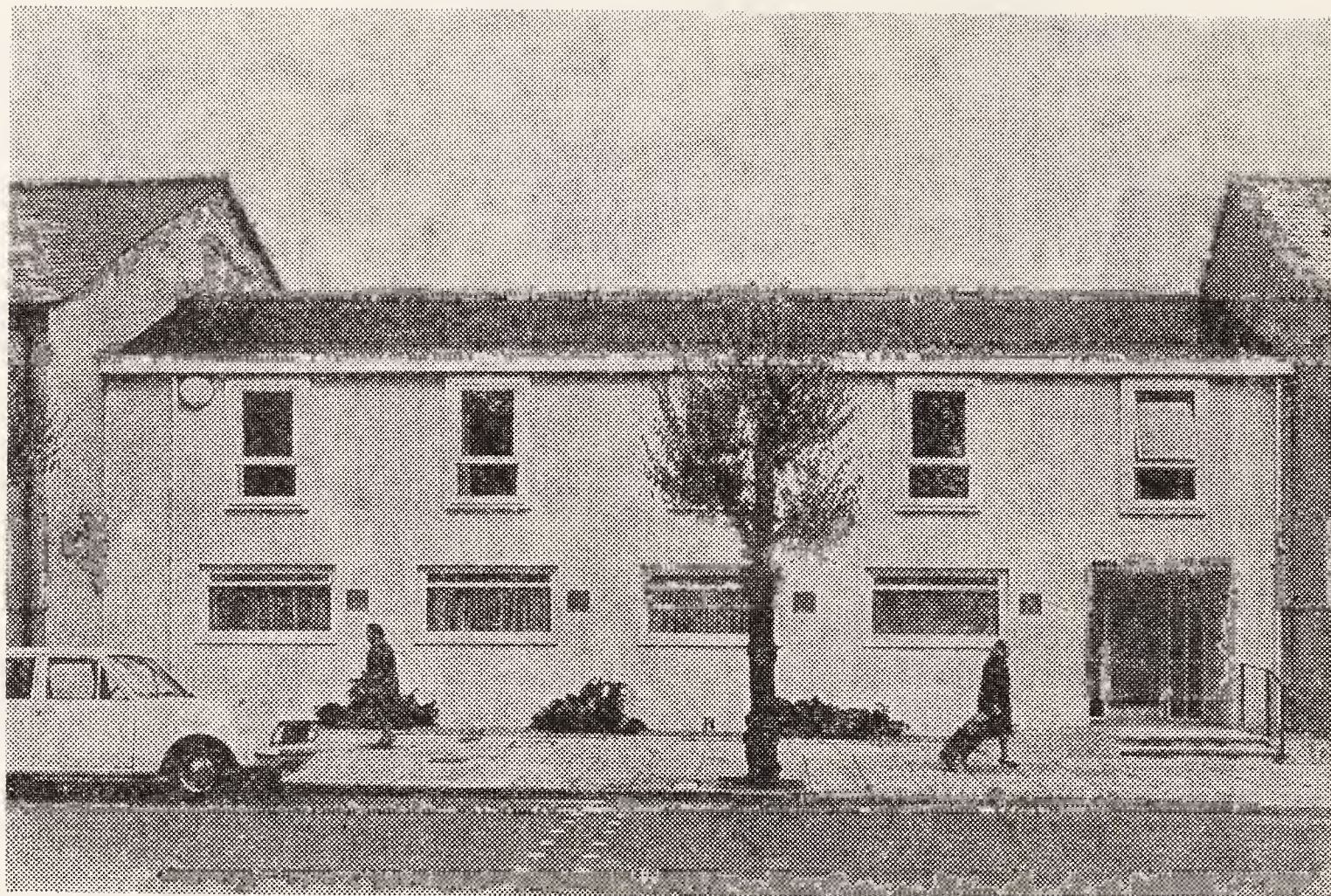
HEALTH CENTRES

Completed	Year of opening	No. of practices served by Centre	No. of general practitioners using Centre	Special facilities	Centres sited near, adjacent to, or in Cottage Hospital Grounds
Ottery St. Mary	1966	1	4	—	—
Budleigh Salterton	1966	1	3	—	—
Buckfastleigh	1966	1	2	—	—
Okehampton	1966	2	4	O	Hospital grounds
Lynton	1966	1	2	—	Adjacent
Ipplepen	1967	1	1	D	—
Ilfracombe	1967	2	4	—	Near
Seaton	1967	1	3	—	—
Kingsteignton	1968	1	2	—	—
Torrington	1968	2	2	D	—
Bovey Tracey	1968	2	2	—	—
Colyton	1968	1	2	—	—
Ashburton	1968	1	2	D	Near
Combe Martin	1968	1	1	—	—
South Molton	1968	2	4	—	Near
Northam	1968	1	3	—	—
Cullompton	1968	1	4	—	—
Ivybridge	1969	2	4	—	—
Yealmpton	1969	1	2	D	—
Salcombe	1969	1	3	—	—
Sidmouth	1969	1	6	—	Adjacent
Holsworthy	1969	1	4	D	—
South Brent	1969	1	1	—	—
Dawlish	1971	2	4	—	Near
Chudleigh	1971	2	3	—	—
Yelverton	1971	1	3	D	—
Chagfor ¹	1971	1	2	D	—
Moretonhampstead	1971	1	2	—	Adjacent
Under Construction:					
Chulmleigh		1	3	D	—
Silverton		1	2	D	—
Kingskerswell		1	2	—	—
Bideford		3	9	—	Hospital grounds
Exmouth		3	10	—	Hospital grounds
1972/73/74 Building Programme:					
Modbury		1	2	D	—
Kingsbridge		1	3	O	—
Barnstaple		2	10	D	—
Newton Abbot		1	3	—	Hospital grounds
Broadclyst		1	2	—	—
Horiton		2	4	—	—

D= Dispensary; O—Orthopaedic Clinic.

PROCEDURE FOR THE ESTABLISHMENT OF A HEALTH CENTRE

The request for health centre development in general originates from either the general practitioners serving an area or the Exectuvie Council. In order to explore the possibilities it is necessary to ensure that the local health authority has services in the area so that the centre will be able to form a base for the authority's services as well as those of the general practitioner. From the



Health centre in an urban area.

patient's point of view this has the advantage of providing in one building the facilities needed in connection with maintenance of the health of their families. In exploring the possibilities the general practitioner will wish to be reassured as to his independence, the method of appointing staff at the centre, the amount of consultation that will take place regarding the design and layout of his consulting rooms, treatment and reception areas, and the choice he will have in selecting furniture and equipment. The next step will be to determine the local authority's needs, which may include provision for a departmental medical officer and dental suite, accommodation for the community nursing staff, a chiropodist and speech therapist as well as the needs of other county council departments such as social services, who may wish to be provided with interview facilities for social workers, home help organisers and occupational therapists. The education department may require a base for a remedial teacher, an educational psychologist, or a teacher of the deaf. In some areas provision will have to be made for child guidance facilities. Consultation will take place with the local hospital management committee to see if they wish to share any of the accommodation or be provided with specialist facilities for the area.

It is necessary for the project to appear in the local authority's capital building programme, which is submitted annually to the health committee for approval prior to submission to the county council and the Department of Health and Social Security.

The particular requirements of all interest participants are noted and included in a schedule that is sent to the county architect. At the same time the county sites team, which consists of representatives of the following departments—county architect's, county estates surveyor, county planning officer's and county surveyor's—are asked to suggest suitable sites for the development. It will then be necessary to consult with the general practitioners and the health committee's sites team, which is a team of members including the local county councillor and the respective chairmen of the health committee, local medical

committee and Executive Council. It is necessary to obtain their agreement to the proposed site.

In order to obtain outline planning approval to the development the local council has to be consulted before the county estates surveyor can be instructed to open negotiations to purchase the site. The county architect will have, by now, provided an initial sketch plan which will then be discussed with the general practitioners and the Clerk of the Executive Council. Guidance on the maximum size of rooms and total accommodation that can be allowed for populations of up to 30,000 is provided in the design guide on health centre development prepared by the Department of Health and Social Security. The general practitioners will be especially interested, in considering the sketch plan, in the siting of their consultation suites in relation to the reception, waiting and treatment areas.

At this time the question of an appointment system will be discussed as this has a bearing on the amount of waiting accommodation that must be provided. This sketch plan will also be discussed with the local health authority staff. Once agreed it is then submitted to the health committee with an estimate of the costing, so that it can be forwarded to the Department of Health and Social Security for approval of the plan and authorisation for loan sanction.

With the larger and more complex health centre plans it is often an advantage, in obtaining agreement, to arrange a discussion with representatives of the Department of Health and Social Security at which the general practitioner, county architect and the Clerk of the Executive Council, as well as the County M.O., are present. When the sketch plan has been approved there will be a further meeting with the general practitioner, county architect, the Clerk of the Executive Council and a representative of the G.P.O., to discuss telephone arrangements and design details for individual areas in the centre. The G.P.O. representative will advise on the number of external lines required, the number of internal extensions, extensions to the doctor's home, ansafone etc., together with the type of exchange equipment, which is usually a PMBX or PABX. Details will also be agreed regarding the form of entry in the telephone directory. The rental for the telephone equipment is charged to the general practitioner on a proportion of the internal extensions for his exclusive use. Direct lines to the doctor's home, and ansafone arrangements have to be charged wholly to the doctors. It will be necessary to decide whether free-standing or wall-mounted phones will be required, together with their precise positioning in the rooms, so that this can be indicated on the architect's plan.

When the telephone arrangements have been agreed it is an advantage to discuss the position of furniture in the consulting, examination and treatment rooms. This will permit the county architect to advise on the position of Sax indicator switches, "patient-ready" signs, power points, the position of built-in cupboards, toilet facilities, bookshelves and clocks. After this meeting the county architect will be able to proceed with his working drawings in order that Bills of Quantities can be prepared prior to tenders being invited.

It will be explained to the general practitioner that his ancillary staff, both part-time and full-time, will normally be transferred to the county council and paid on their scales—J.I.C. for clerical staff and Whitley for nursing staff. This has the advantage of relieving the doctors of arranging for payments of salaries, as this is undertaken by the county council, who reclaim the payment from the Executive Council so that they can arrange for the appropriate percentage of reimbursement to the doctor. The doctor is therefore relieved of making graduated insurance deductions, tax deductions, or making claims for reimbursement from the Executive Council.

The general practitioner will be made aware of the fact that the Executive Council will accept full responsibility for payment of rent and rates on the accommodation occupied exclusively by the doctor, as well as that which is shared with the authority in the centre, and no cost for this falls on the practice. The charge to the practice, in addition to the telephone, is an agreed proportion of the heating, lighting, cleaning and laundry charges, plus an annual sum towards internal repairs and redecoration, which ensures that the surgery accommodation will be redecorated every five years. The other charge will be for items of furniture and equipment provided; that which is exclusively for the use of the general practitioners, i.e. items mainly in his consulting and examination room, are at an annual rental of 10% of the cost, whereas those items which are shared in the reception office, treatment and waiting areas, will be charged at 2½%, the only exception being for items such as E.C.G. where the rental charge is 15% of the cost, due to possible high maintenance charges. The account is submitted half-yearly to the Executive Council, who normally arrange for a fixed sum to be deducted from the payments to the practice.

At a later stage there will be a further meeting when the actual selection of the type of furniture to be provided can be agreed, together with the selection of the colour scheme for the walls, curtains, venetian blinds, carpets and nylon felt floor covering for the centre. The order for furniture and equipment is normally placed some three/four months before the completion of the project, as there can be considerable delays in the delivery of some specialist items.

Prior to the opening of the building there will be discussions with the doctors regarding the appropriate position of the county council salary scale for the payment of their existing staff. At the same time it will be decided whether there is a need for advertising for additional staff. Appointment of the new staff will be made by the general practitioner in conjunction with a member of the staff of the health department.

Efforts are made to ensure that the building is ready for occupation three/four weeks prior to the opening date, in order that sufficient time is available for the laying of carpets and hanging of curtains, delivery of furniture and the arranging of demonstrations of cleaning and telephone equipment.

It is generally found that the minimum period between the initial request from the general practitioner regarding the possibility of health centre development for his area and the opening of the new building will be approximately three years.

PART V

ENVIROMENTAL HYGIENE

Fluoridation of Water Supplies

ENVIRONMENTAL HYGIENE

Food and Milk

The County Council employs five Sampling Officers, who are always available to investigate consumer complaints. Their names and addresses are shown in Appendix K, but if it is more convenient, a 'phone call to the Local District Council Offices or to this Department will ensure the speedy attention which is so essential.

The Sampling Officers, in addition to dealing with consumer complaints, obtain routine samples of every type of commodity which is used for human consumption, as food or drink, and the Public Analyst normally finds that at least 95% of all the samples submitted to him are completely satisfactory. Even in the remaining 5% of cases, informal action will normally put matters right, but the County Council would not hesitate to initiate a prosecution if the circumstances warranted it. A following paragraph gives a list of the foreign bodies which have been found in food recently, and the list makes very interesting reading.

The five Sampling Officers in the county are supervised by the County Health Inspector. Food and Drugs samples other than milk are sent to the Public Analyst for examination, but the majority of milks are subjected to the Gerber Test in this Department and only the suspicious samples are submitted to the Public Analyst. In addition, a proportion of samples are sent each week for testing for the presence of Antibiotics and Pesticidal Residues.

During the period, 1,412 formal and 893 informal samples were submitted to the Public Analyst, whilst 1,530 samples of milk were subjected to the Gerber Test in the Department's own laboratory.

The Public Analyst reported that of the 2,305 samples he received, 134 were either adulterated or gave rise to some other irregularity. 24 of the samples were of milk, and 17 of these were ones in which the non-fatty solids and/or butter fats were below the normally accepted figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food and Drugs Act was being committed. Of the remainder, four were found to contain added water and one contained a small amount of Penicillin. Two vendors were prosecuted.

The remaining 110 samples, other than milk reported on by the Public Analyst, included: a bee embedded in a swiss roll, a blue-bottle fly in a packet of tea, a packet of cereal containing mouse excreta, fragments of meat embedded in frozen puff pastry, a can of peeled tomatoes containing a shiny ground beetle, bottle of milk containing glass, instant coffee containing glass fragments, steak and kidney pie containing a lesser house fly, a can of pork luncheon meat containing a piece of adhesive film from a fabric backed adhesive strip, a can of corned beef containing large iron nut with part of an iron bolt, six small pieces of wood in a can of corned beef, tin of blackcurrants containing a piece of wood, a piece of tinned iron in a steak and kidney pie, a one-and-a-quarter inch wire nail in a date and walnut cake, a fragment of ox hide with hair attached in a steak and kidney pie, ham sandwiches infested with maggots, a head of a wasp in a brown loaf, a packet of ground rice containing four larvae of the confused flour beetle, a brown loaf containing a small piece of wire and string cord, milk bottles containing decayed vegetable matter and mould, milk bottle with larvae of the phorid fly adhering to the inside, cashew nuts heavily infested with active Australian spider beetles, and a piece of pork contaminated with dead larvae of the cheese skipper fly. 28 of these cases resulted in prosecution and similar action was recommended in others; warning letters were sent concerning many of the remaining offences.

The sampling officers take their samples with very considerable care and selectivity. Apart from the help given in this Department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other counties and published accounts of the legal action taken by other Food and Drugs authorities.

All complaints of alleged infringement of the principal Acts or the many Regulations, etc., made under them are very carefully examined and the co-operation of the public and of other local authorities is welcomed. I hope that this assistance will increase in the future.

Brucella Abortus

A sampling programme to identify herds secreting the Brucella organism in their milk was commenced in 1963, and in the first four years the number of individual samples found to be Positive averaged between 30 and 40.

Most authorities are satisfied that the consumption of infected raw milk is a public health risk, which should be prevented wherever possible, and in 1966 the Ministry of Health issued a circular advocating the regular sampling of milk from all herds whose milk was sold untreated.

As a result, our sampling programme was stepped up even more, and in 1970, 43 Positive cultures were isolated and 31 in 1971.

Immediately a positive culture is known, the Medical Officer of Health for the district and the Divisional Veterinary Officer are informed and steps are taken to prohibit the sale of the infected milk and to trace the offending animal or animals. Normally, two consecutive negative results are required before the raw milk is allowed to be consumed again and the number of samples taken is increased.

Total number of samples of Untreated Milk submitted	...	3,482
Number Positive on Ring Test, but Negative on Culture	...	132
Number Positive on Culture	... ..	74

The Milk (Special Designation) Regulations 1963

During the period the following samples where submitted:

			<i>Total</i>	<i>Number failed Phosphatase test</i>
Pasteurised	...	...	2,220	2
			<i>Total</i>	<i>Number failed Methylene Blue test</i>
Pasteurised	...	...	2,220	109
Untreated...	...	...	1,513	279
			<i>Total</i>	<i>Number failed Turbidity test</i>
Sterilised .....	...	...	28	Nil
			<i>Total</i>	<i>Number failed Colony Count</i>
Ultra Heat Treated	...	77		Nil

When a sample fails to pass the prescribed test, an immediate inspection of the dealer's premises is made and repeat samples are taken where necessary. If it is thought that the failure, in the case of untreated milk, is the fault of the producer, the Ministry of Agriculture, Fisheries and Food's Divisional Milk Officer is informed.

MILK

The County Dairy Husbandry Adviser of the Ministry of Agriculture, Fisheries and Food, informs me that at the end of 1971, there were 6,124 registered milk producers; and 490 licences permitting the sale of "Untreated" milk by producer/retailers were in operation.

ANIMAL HEALTH DIVISION—DEVON

The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food, Mr. G. S. Reid Chalmers, reports as follows:

Livestock Census

Cattle	...	...	614,646	Pigs	...	...	278,641
Sheep	...	...	1,221,303	Poultry	...	...	4,551,757

Eradication of Tuberculosis

<i>No. of herds tested</i>	<i>No. of cattle tested</i>	<i>No. of herds in which reactors were disclosed</i>	<i>No. of reactor herds in which lesions were found at post mortem</i>	<i>Reactors Showing lesions at post mortem</i>	<i>Disclosed Showing no lesions at post mortem</i>
4,061	170,946	6	9	2	7

Scheduled Diseases

There were four suspected cases of Foot and Mouth Disease, which were not confirmed, two suspected cases of Swine Fever which proved negative, and 50 reported cases of Fowl Pest, of which 29 were positive and 21 negative; 376 cases of Anthrax were reported, of which three were confirmed.

Free Calf Vaccination Service

No. of herds registered at 31st December, 1971, for Free Calf Vaccination Service	...	...	...	...	...	7,910
No. of calves vaccinated in 1971	...	...	...	...	...	55,173

Brucellosis Accredited Herds Scheme

No. of herds participating in the scheme at 31st December, 1971	3,644
No. of accredited herds at 31st December, 1971	1,720

WATER SUPPLIES

Owing to financial stringency, the number of water main extensions has slowed down, but it is fair to say that the Water Boards had almost reached the end of their most urgent main laying programmes; 1972 should see the momentum increasing again but, looking to the years to come, it is obvious that the chief problem will be the provision of very large permanent sources of supply to meet the anticipated demands of the years up to A.D. 2000.

Water Boards in the county have all been active during the period and all have substantial schemes either in course of construction or awaiting the consent of the Ministry of Housing and Local Government. This progress is emphasised by the amount of precept which each Board makes on the County Council.

Comparative figures are as follows:

	1969-70 <i>Actual Cost</i> £	1970-71 <i>Actual Cost</i> £	1971-72 <i>Probable Cost</i> £
North Devon Water Board	227,500	237,234	275,000
South West Devon Water Board	47,500	48,638	58,000
East Devon Water Board	36,783	43,929	34,050

The North Devon Water Board now covers an area of 1,664 square miles, approximately 1,382 miles of mains have been laid, and the average quantity of water supplied is over 10.7 million gallons per day. The total capital expenditure to 21st March, 1971, was £9,037,757.

The South West Devon Water Board was formed under Ministerial Order to operate from 1st October, 1963, and its statutory area includes the County Borough of Torbay, the Boroughs of Dartmouth and Totnes, the Urban Districts of Ashburton, Buckfastleigh, Dawlish, Kingsbridge, Newton Abbot, Salcombe and Teignmouth, the Rural Districts of Kingsbridge, Newton Abbot and Totnes and that part of the Rural District of St. Thomas lying to the south of the River Exe. The area is approximately 500 square miles and the total amount of water put into supply in 1971 was 4,828 million gallons, or 13.18 million gallons per day with a summer peak of 16.56 million gallons per day. 1,206 miles of main have been laid and the total capital expenditure is £8,333,533.

The East Devon Water Board was reconstituted on the 1st October, 1964, and now comprises the authorities of the original Board, together with the County Borough of Exeter, the Urban Districts of Budleigh Salterton, Exmouth, Seaton and Sidmouth, the whole of the St. Thomas Rural District area east of the River Exe and the District Water Undertaking of the Colyton Feoffees. The total area covered by the Board amounts to 343 square miles. The total capital expenditure of the authorities included in the Board amounted to approximately £5,950,000 up to 31st March, 1971. The average daily quantity of water supplied up to 31st December, 1971, was 48,463 cubic metres; and 315 miles of pipes were laid up to that date.

During the period, grants under the Rural Water Supplies Act were agreed to in principle on the following schemes:

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost</i> £
West Somerset Water Board	Holcombe Rogus	2,800
South West Devon Water Board	Abham, Staverton	2,595
	Allaleigh, Cornworthy	1,600
	Avon Mill, Loddiswell	1,450
	Bigbury, Ringmore, Kingston and Modbury	81,000
	Combe area of Ideford	1,300
	Copplestone Farm area, Bridford	2,400
	Cotmore, near Stokenham	2,850
	Galmpton Creek	3,850
	Kerswell area, Chudleigh	2,350
	Marsh Lane Cross, Chudleigh	3,675
	Moretonhampstead, North Bovey, Manaton and Lustleigh	125,250
	Palace Cottages, North Filham, near Bittaford	800
	Radford and Bow Mills, Broadhempston	1,756
	Uphempston area, Totnes	3,500
	Venn Farm area, Teignmouth	3,500
	West Prawle, East Portlemouth	1,050
	Widewell, Stokenham	1,700

SEWERAGE AND SEWAGE DISPOSAL

Here again, financial stringency has somewhat curtailed the number of schemes which were carried out in 1970 and 1971, but there is every reason to suppose that there will be a new impetus in 1972. Much more remains to be done than in the case of water supply, and during the next decade it is quite clear that a number of villages which were given Sewerage and Sewage Disposal Schemes in the 1930s will now have to be provided with modern and extended systems. I cannot, therefore, foresee any slowing down in this sphere.

The following schemes submitted to the County Council for financial assistance were examined by the County Health Inspector and were also submitted to the County Planning Officer for his examination, with the result that a joint report was made to the General Purposes Sub-Committee of the Health Committee from both Departments.

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost</i> £
Ashburton U.D.C.	Scheme No. 3	13,000
Ashburton U.D.C.	Scheme No. 4	53,000
Axminster R.D.C.	Phase II	353,000
Axminster R.D.C.	Axmouth	39,000
Axminster R.D.C.	Colyton/Colyford	110,500
Barnstaple R.D.C.	Berrynarbor	10,000
Barnstaple R.D.C.	Marwood	75,000
Barnstaple R.D.C.	Stoke Rivers	13,100
Barnstaple R.D.C.	Westleigh	15,500
Buckfastleigh U.D.C.		85,000
Bideford R.D.C.	Littleham	4,880
Bideford R.D.C.	Parkham	5,130
Exmouth U.D.C.	Straight Point	123,000
Exmouth U.D.C.	Straight Point—Maer Rocks	
	Outfall	10,000
Exmouth U.D.C.		7,000
Great Torrington B.C.	Burwood Residential Land	60,168
Holsworthy R.D.C.	Broadwoodwider	16,070
Holsworthy R.D.C.	Northern Area	1,808
Holsworthy R.D.C.	Pyworthy	34,002
Holsworthy R.D.C.	St. Giles-on-the-Heath	38,000
Honiton R.D.C.	Branscombe	63,000
Honiton R.D.C.	Broadhembury	55,000
Honiton R.D.C.	Dulford	10,930
Ilfracombe U.D.C.		64,015
Kingsbridge U.D.C.		350,000
Kingsbridge R.D.C.	Modbury	220,000
Newton Abbot U.D.C.	Keyberry Road	53,000
Newton Abbot R.D.C.	Bovey Tracey	15,200
Newton Abbot R.D.C.	Buckland	1,785,000
Newton Abbot R.D.C.	Church Road and Radway Street, Bishopsteignton	21,000
Newton Abbot R.D.C.	Hackney Marshes and The Butts, Kingsteignton	3,620
Newton Abbot R.D.C.	Lustleigh	15,741
Newton Abbot R.D.C.	Moretonhampstead	160,000
Newton Abbot R.D.C.	Ponsworthy	17,810
Newton Abbot R.D.C.	Teigngrace	18,365

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost £</i>
Okehampton R.D.C.	Jacobstowe	16,598
Ottery St. Mary U.D.C.	Gerway and Otter Valley	135,902
St. Thomas R.D.C.	Cowley and Three Horseshoes	30,000
St. Thomas R.D.C.	Dunsford	136,500
St. Thomas R.D.C.	Lympstone and Woodbury	1,260,000
St. Thomas R.D.C.	Otter Valley Stage II	48,000
Seaton U.D.C.		372,291
Sidmouth U.D.C.	Salcombe Regis	15,400
South Molton R.D.C.	Burrington	17,200
South Molton R.D.C.	Witheridge	30,000
Tavistock R.D.C.	Axtown/Stoke Hill	3,250
Tavistock R.D.C.	Buckland Monachorum	21,980
Tiverton R.D.C.	Kentisbeare and Blackborough	116,000
Tiverton R.D.C.	Thorverton	150,300
Tiverton R.D.C.	Uffculme	22,000
Torrington R.D.C.	Beaford	87,000
Torrington R.D.C.	High Bickington	81,000
Totnes B.C.		270,000
Totnes R.D.C.	Aish, South Brent	1,800
Totnes R.D.C.	South Brent	285,000
Totnes R.D.C.	Tuckenhay	39,091

FLUORIDATION OF WATER SUPPLIES

Despite the County Health Committee's having pronounced in favour of fluoridation, the County Council met to debate the issue in February 1970, and voted 42-19 against the principle of fluoridation. Thus for the second time in four years, the County Council has cast aside the opportunity to reduce dental caries in Devon's children and future adults. As long as this policy is pursued, the demands of an increasing school population in Devon will inevitably call for dental staff increases to meet these demands.

STATISTICAL APPENDIX

Births and Deaths	...	...	...	...	...	...	...	...	A
Statistics—County of Devon 1970 and 1971					...	...	...	...	B
Premature Births	...	...	...	...	...	...	...	...	C
Mortality Rates	...	...	...	...	...	...	...	...	D
Causes of death	...	...	...	...	...	...	...	...	E
Causes of death at different periods of life 1970 and 1971							...	...	F
Number of children who received immunisation	...				...	...	...	...	G
Dental inspection and treatment	...	...	...	...	...	...	...	...	H
Epidemiology: incidence and notification of infectious diseases...								...	I
Tuberculosis: notifications deaths treatment—chest clinics					...	...	...	...	J
Sampling Officers	...	...	...	...	...	...	...	...	K

Births

Registered live births in 1971 were 5,895 compared with 5,882 in 1970.

The corrected live birth rates for the past ten years for the boroughs and urban disticts, rural districts and the administrative county, together with the national rate, are set out below:

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>	<i>England and Wales</i>
1962	14.8	17.8	16.1	18.0
1963	17.4	18.3	17.9	18.2
1964	18.3	18.4	18.3	18.4
1965	17.7	18.4	18.2	18.0
1966	17.6	17.7	17.6	17.7
1967	17.6	16.8	17.2	17.2
1968	17.3	16.8	17.0	16.9
1969	17.3	16.2	16.6	16.3
1970	17.7	15.6	16.5	16.0
1971	17.3	15.2	16.1	16.0

Deaths

The total number of deaths allocated to the administrative county was 6,763 in 1970 and 6,620 in 1971 compared with 6,631 in 1969.

Due to the age/sex distribution of the population differing from area to area throughout the county, crude rates although based on actual occurrences fail to provide a useful mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past six years, adjusted by the appropriate factors, for the aggregates of boroughs and urban districts, rural districts and the administrative county, also the rates for England and Wales, are given below.

Adjusted Death Rates

<i>Year</i>	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>	<i>England and Wales</i>
1966	10.7	10.4	10.6	11.7
1967	9.7	9.9	9.8	11.2
1968	9.9	10.9	10.4	11.9
1969	10.0	10.5	10.4	11.9
1970	10.0	10.5	10.4	11.7
1971	9.4	10.1	9.9	11.6

Districts	Populations (Estimated) Home	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer and Malignant and Other Unspecified Neoplasms	Vascular and Other Lesions of the Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach and Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths			
			No.	Rates per 1,000 Population	No.	Under 4 weeks	No.											4 weeks and under 1 year	No.	Crude Rate	Cor'd Rate
Budleigh Salterton Exmouth St. Thomas	3,940 23,790 30,700	1,360 7,210 4,740	33 316 326	8.4 13.3 10.6	13.5 19.3 11.6	— 3 5	— — 1	— 1 2	19 84 81	17 75 48	37 190 164	13 72 129	1 18 11	2 5 3	— — 1	3 22 24	1 22 30	93 489 493	23.6 20.6 16.0	10.9 9.9 9.8	
Ottery St. Mary Sidmouth Honiton Seaton Axminster Honiton	5,960 12,500 6,080 4,000 14,750 7,780	880 4,310 680 1,250 3,200 1,380	88 88 98 35 177 137	14.8 7.0 16.1 8.8 12.0 17.6	22.2 14.6 18.7 15.8 15.7 20.6	1 2 3 — 3 2	— 1 1 — 2 1	— 1 — — 2 1	6 52 10 16 39 18	9 45 30 19 28 12	37 95 32 38 60 32	14 28 14 11 26 9	1 5 — — 3 3	2 — 2 — 4 5	— — — — — —	3 14 4 1 9 3	4 7 3 2 6 6	76 247 95 87 177 89	12.8 19.8 15.6 22.0 12.0 11.4	7.3 8.3 9.0 8.6 9.4 10.4	
Crediton Crediton Tiverton Tiverton	5,190 9,830 15,140 20,690	870 1,540 2,590 3,900	78 163 288 308	15.0 16.6 19.0 14.9	15.6 18.6 20.1 16.8	— 2 4 2	1 2 4 —	— — — 1	13 21 43 55	6 16 49 50	19 43 66 99	13 28 18 47	1 — 2 7	2 3 1 5	— — — —	5 6 15 13	4 8 7 12	63 125 201 289	12.1 12.7 13.3 14.0	10.9 11.8 10.8 11.6	
Barnstaple Barnstaple South Molton Ilfracombe Torrington Torrington Northam Bideford Holsworthy Great Torrington Bideford Lynton	16,920 28,870 11,070 8,170 7,240 7,650 11,500 8,270 3,200 5,070 1,710	2,420 5,140 1,730 2,070 1,270 1,770 1,560 1,570 510 740 430	278 391 134 127 95 80 154 122 43 72 26	16.4 13.5 12.1 15.5 13.1 10.5 13.4 14.8 13.4 14.2 15.2	17.2 16.1 14.4 19.8 15.6 15.3 15.1 17.2 15.9 16.5 17.3	5 3 2 1 1 2 3 2 1 — —	1 1 — — — 2 — — — — —	2 2 — — 1 — 1 — 1 — —	40 88 26 23 26 36 32 10 10 8 7	37 63 29 35 12 16 32 18 9 10 9	79 167 58 63 45 48 75 42 27 22 14	31 27 16 23 10 9 24 7 4 8 2	1 11 10 3 2 5 3 7 2 — 1	1 2 2 1 — 1 1 2 1 — —	11 16 12 6 7 6 5 9 4 4 1	8 12 7 10 5 2 4 1 — — 2	210 388 160 164 108 123 177 96 58 52 36	12.4 13.4 14.5 20.1 14.9 16.1 15.4 11.6 18.1 10.3 21.1	9.5 10.9 11.7 12.7 13.4 9.3 11.9 9.5 10.9 9.7 12.9		
Salcombe Kingsbridge Kingsbridge Plympton St. Mary Tavistock Totnes Totnes Buckfastleigh Dartmouth	2,420 3,520 12,130 14,620 23,500 13,990 5,700 2,440 7,130	460 480 2,590 1,770 3,930 2,900 1,200 470 1,130	18 52 125 189 370 142 81 39 65	7.4 14.8 10.3 12.9 15.7 10.2 14.2 16.0 9.1	9.8 17.3 12.6 13.3 18.8 12.8 16.9 21.3 10.3	2 — 1 2 7 2 1 — —	— 1 1 — 2 — — 1 —	— — 1 — — — — — —	5 9 33 38 61 38 17 13 22	7 9 29 25 51 47 24 5 16	14 16 66 69 124 85 41 20 37	5 5 13 24 42 45 7 2 10	1 — 3 2 10 5 1 3 1	— — 4 3 3 — 4 — 1	3 1 6 8 10 8 20 2 1	— 2 3 5 10 6 4 1 —	35 42 158 174 313 234 118 46 88	14.5 11.9 13.0 11.9 13.3 16.7 20.7 18.9 12.3	10.3 10.6 10.5 10.5 10.6 8.5 11.2 14.2 10.8		
Ashburton Dawlish Teignmouth Newton Abbot Newton Abbot	3,520 8,420 12,290 18,610 28,730	610 2,620 2,520 3,670 6,210	63 121 145 271 359	17.9 14.4 11.8 14.6 12.5	22.0 19.4 18.3 16.2 14.8	1 2 1 1 6	— 1 — 3 2	— — — 4 4	11 30 48 67 94	1 20 38 58 76	23 63 103 128 175	6 27 34 31 45	1 5 2 8 7	3 — 1 1 12	— — — — —	6 5 7 34 13	1 4 11 15 15	52 154 244 346 441	14.8 18.3 19.9 18.6 15.3	9.8 11.9 10.1 11.0 11.8	
Okehampton Okehampton	3,900 11,110	790 2,010	59 126	15.1 11.3	17.1 14.5	1 4	— —	— 1	15 21	12 24	28 51	16 19	2 5	5 1	— —	3 7	3 9	84 138	21.5 12.4	15.1 9.9	
Administrative County	442,050	86,480	5,882	13.3	16.5	78	29	27	1,285	1,116	2,595	914	153	83	1	337	252	6,763	15.3	10.4	

Districts	Populations (Estimated) Home	Estimated Populations Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer and Malignant and Other Unspecified Neoplasms	Vascular and Other Lesions of the Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach and Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
			No.	Rates per 1,000 Population	Under 4 weeks	4 weeks and under 1 year	No.											Crude Rate	Cor'd Rate	
Budleigh Salterton U.D. Exmouth U.D. St. Thomas R.D.	4,160 25,470 28,170	1,440 7,720 4,350	33 317 323	7.9 12.4 11.5	12.7 18.0 12.5	— 2 2	— 2 2	1 3 6	23 108 75	18 59 68	38 181 158	5 35 86	1 12 7	— 2 5	— — —	1 14 18	3 13 35	90 427 458	21.6 16.8 16.3	9.9 8.1 9.9
Ottery St. Mary U.D. Sidmouth U.D. M.B. Honiton U.D. Seaton U.D. Axminster R.D. Honiton R.D.	5,890 11,610 4,940 4,170 15,150 7,610	870 4,000 550 1,300 3,290 1,350	73 109 96 52 172 130	12.4 9.4 19.4 12.5 11.4 17.1	18.6 19.6 22.5 22.4 14.9 20.0	— — — — 3 1	— — — — — —	— 1 — — — —	15 51 15 24 44 10	10 39 30 20 37 14	34 82 27 41 71 37	9 19 9 3 13 9	1 3 4 2 3 3	2 — 2 2 — 2	3 8 5 1 12 2	2 9 1 2 9 5	76 212 93 95 189 82	12.9 18.3 18.8 22.8 12.5 10.8	7.4 7.7 10.9 8.9 9.8 9.8	
Crediton U.D. Crediton R.D. M.B. Tiverton R.D.	5,390 10,220 15,660 21,560	900 1,600 2,680 4,060	74 142 274 293	13.7 13.9 17.5 13.6	14.2 15.6 18.6 15.4	— 1 3 —	1 — 1 2	— 1 — —	16 20 26 73	12 18 26 39	41 33 69 91	14 9 32 26	2 — 9 5	— 2 — 3	— — — —	3 2 7 9	4 4 8 13	92 89 177 259	17.1 8.7 11.3 12.0	15.4 8.1 9.2 10.0
Barnstaple M.B. Barnstaple R.D. South Molton R.D. Ifracombe U.D. Torrington R.D. Northam U.D. Bideford M.B. Holsworthy R.D. Great Torrington M.B. Bideford R.D. Lynton U.D.	17,590 30,910 11,250 8,960 7,680 8,070 11,850 8,660 3,440 5,030 1,700	2,520 5,500 1,760 2,270 1,350 1,870 1,610 1,640 550 730 430	324 417 117 113 119 84 186 123 49 75 24	18.4 13.5 10.4 12.6 15.5 10.4 15.7 14.2 14.2 14.9 14.1	19.3 16.1 12.4 16.1 18.4 15.2 17.7 16.5 16.9 17.3 16.1	2 2 2 — — 1 1 1 1 —	1 3 1 — 2 — 1 2 — — —	1 4 — — — 1 1 — — — — —	59 81 29 31 19 31 41 21 9 10 4	47 50 19 24 13 24 24 13 15 13 3	104 170 54 72 42 58 84 54 20 22 13	18 38 14 11 11 18 15 9 6 — 4	8 7 5 6 4 2 4 2 — 1 2	2 9 1 3 1 2 4 2 1 1 —	6 12 15 4 6 5 6 4 4 7 —	7 15 6 7 1 2 7 4 — 1 1	252 387 143 158 97 143 186 109 55 55 27	14.3 12.5 12.7 17.6 12.6 17.7 15.7 12.6 16.0 10.9 15.9	11.0 10.1 10.3 11.1 11.3 10.3 12.1 10.3 9.6 10.2 9.7	
Salcombe U.D. Kingsbridge U.D. Kingsbridge R.D. Plympton St. Mary R.D. Tavistock R.D. Totnes R.D. Totnes M.B. Buckfastleigh U.D. Dartmouth M.B.	2,310 3,540 12,360 15,240 24,240 15,070 5,720 2,690 6,570	440 480 2,640 1,850 4,050 3,120 1,200 520 1,040	27 39 127 191 311 147 74 35 89	11.7 11.0 10.3 12.5 12.8 9.8 12.9 13.0 13.5	15.6 12.9 12.6 12.9 15.4 12.3 15.4 17.3 15.5	— 1 — — 8 3 — 1 2	— — — 3 2 1 — — —	— 1 — 1 3 2 — — 3	7 7 46 35 74 52 24 12 22	5 7 33 33 44 49 11 6 10	10 20 73 68 123 82 30 18 28	6 4 10 18 41 44 11 1 9	— 2 7 9 7 3 3 3 2	1 — 3 4 2 4 — 1 1	— — 12 4 28 17 16 5 7	1 1 5 7 14 6 4 — 3	30 44 189 179 336 259 99 46 85	13.0 12.4 15.3 11.7 13.9 17.2 17.3 17.1 12.9	9.2 11.0 12.4 10.3 11.1 8.8 9.3 12.8 11.4	
Ashburton U.D. Dawlish U.D. Teignmouth U.D. Newton Abbot U.D. Newton Abbot R.D.	3,470 9,500 12,610 19,680 30,570	600 2,960 2,590 3,880 6,610	51 101 138 255 407	14.7 10.6 10.9 13.0 13.3	18.1 14.3 16.9 14.4 15.7	— 3 1 4 2	— — 1 2 1	— — — 2 2	12 35 50 56 102	11 16 51 48 62	15 61 91 148 158	5 18 19 25 35	3 — 10 4 14	2 — 3 9 5	— — — — —	1 5 15 39 20	3 3 8 10 11	52 138 247 341 409	15.0 14.5 19.6 17.3 13.4	9.9 9.4 10.0 10.2 10.3
Okehampton M.B. Okehampton R.D.	4,050 10,960	820 1,980	51 133	12.6 12.1	14.2 15.5	2 1	— —	— 1	13 33	8 24	23 56	10 16	5 2	3 2	— —	4 5	3 7	69 146	17.0 13.3	119 10.6
Administrative County	453,720	89,120	5,895	13.0	16.1	50	28	34	1,415	1,053	2,600	685	167	86	1	334	245	6,620	14.6	9.9

Premature live births in 1971 totalled 309. Of this number only 32 failed to survive the first 28 days of life. Table A shows the birth weight, place of birth and number of babies surviving in each group at the end of 28 days.

Table A

		Premature live births—Total notified 334												Premature Stillbirths	
		Born in hospital						Born at home or in a nursing home							
		Died			Total Births			Died			Total Births			Transferred to hospital on or before 28th Day	
		within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days	(2)	(3)	(4)	within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days	(6)	(7)	(8)		
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)		
		Total Births	within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days	Total Births	within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days	Total Births	within 24 hours of Birth	in 1 and under 7 days	in 7 and under 28 days	Born	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	in hospital	at home or in nursing home
Weight at birth		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lb. 3 oz. or less	... ..	10	3	5	1	3	—	1	—	1	—	—	—	10	1
2. Over 2 lb. 3 oz. up to and including 3 lb. 4 oz.		29	8	4	1	—	—	—	—	1	—	—	—	11	2
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz.		49	4	—	1	1	—	—	—	1	1	—	—	7	1
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz.		61	1	—	—	1	—	—	—	2	—	—	—	4	—
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz.		143	1	—	1	3	—	—	—	4	—	—	—	3	—
6. Total	... ..	292	17	9	4	8	—	1	—	9	1	—	—	35	4

Mortality Rates (Devon and England and Wales)

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
<i>Stillbirths</i>										
Devon	15.0	16.9	17.3	15.9	12.1	12.8	11.0	11.6	11.4	12.1
England and Wales	18.1	17.2	16.4	15.7	15.4	14.8	14.0	13.2	13.0	12.5
<i>Neo-natal Deaths</i>										
Devon	11.6	13.6	10.8	9.1	11.5	7.3	8.3	8.6	13.3	8.5
England and Wales	15.1	14.2	13.8	13.0	12.9	12.5	12.3	12.0	12.3	11.6
<i>Early Neo-natal (first week) Deaths</i>										
Devon	9.5	11.9	9.3	7.5	9.0	5.9	6.1	7.0	10.9	6.8
England and Wales	13.0	12.3	12.1	11.3	11.1	10.8	10.5	10.3	10.6	9.9
<i>Perinatal Mortality</i>										
Devon	24.4	28.5	26.5	23.3	21.0	18.6	17.0	18.6	22.2	18.8
England and Wales	30.8	29.3	28.2	26.9	26.3	25.4	25.0	23.4	23.5	22.2

Causes of Death

Deaths are classified under the headings based on the International Abbreviated List (B List) from the manual of the Eighth Revision of the International Classification.

Principal Causes of Death

The main causes of death remained as in recent years.

The relative contributions of the diseases, which accounted for 91.12% of the total mortality in 1970 and 90.6% in 1971 are indicated below.

Percentage Contributions of Total Causes

<i>Main Causes</i>		1967	1968	1969	1970	1971
Heart and Circulatory Diseases	...	40.60	39.16	38.80	38.37	39.27
Malignant Neoplasms ...	...	19.04	19.11	19.92	19.00	21.37
Vascular Lesions of Nervous System...		16.31	16.29	15.99	16.51	15.91
Disease of Respiratory System	...	8.42	11.81	11.85	13.51	10.35
Accidents, Suicide and Violence	...	3.82	3.65	3.51	3.73	3.70

Appendix F

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1970

B List Number	Causes of Death		Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.1	Cholera	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.2	Typhoid Fever	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.3	Bacillary dysentry and amoebiasis	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.4	Enteritis and other diarrhoeal diseases	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.5	Tuberculosis of respiratory system	.. ..	M	1	—	—	—	—	—	—	—	—	1	2	1
B.6(1)	Late effects of respiratory T.B.	.. ..	F	5	—	—	—	—	—	—	—	—	1	2	2
B.6(2)	Other Tuberculosis	.. ..	M	1	—	—	—	—	—	—	—	—	—	—	—
B.7	Plague	.. ..	F	3	—	—	—	—	—	—	—	—	—	—	—
B.8	Diphtheria	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.9	Whooping Cough	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.10	Streptococcal sore throat and scarlet fever	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.11	Meningococcal infection	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.12	Acute Poliomyelitis	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.13	Smallpox	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.14	Measles	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.15	Typhus and other rickettsioses	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.16	Malaria	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.17	Syphilis and its sequelae	.. ..	F	1	—	—	—	—	—	—	—	—	—	1	—
B.18	All other infective and parasitic diseases	.. ..	M	4	—	1	—	1	—	—	—	—	1	1	1
B.19(1)	Malignant Neoplasm—Buccal cavity, etc.	.. ..	F	9	—	2	—	—	—	—	—	—	—	3	3
B.19(2)	Malignant Neoplasm—oesophagus	.. ..	M	11	—	—	—	—	—	—	—	—	1	8	2
B.19(3)	Malignant Neoplasm—stomach	.. ..	F	5	—	—	—	—	—	—	—	—	2	1	2
B.19(4)	Malignant Neoplasm—intestine	.. ..	M	19	—	—	—	—	—	—	—	—	6	8	5
			F	18	—	—	—	—	—	—	—	—	4	4	10
			M	88	—	—	—	—	—	—	—	3	23	43	19
			F	51	—	—	—	—	—	—	2	2	7	8	32
			M	87	—	—	—	—	—	1	2	4	20	24	36
			F	107	—	—	—	—	—	—	2	2	17	31	55

B List Number	Cause of Death										Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.19(5)	Malignant Neoplasm—larynx...	..	..	..	..	..	..	..	..	..	M	3	—	—	—	—	—	—	—	—	2	—	1
B.19(6)	Malignant Neoplasm—lung, bronchus	..	..	..	..	..	..	..	..	..	F	2	—	—	—	—	—	—	—	—	1	—	—
B.19(7)	Malignant Neoplasm—breast ..	..	..	..	..	..	..	..	..	..	M	201	—	—	—	—	—	—	—	—	56	86	39
B.19(8)	Malignant Neoplasm—uterus ..	..	..	..	..	..	..	..	..	..	F	51	—	—	—	—	—	—	—	—	11	14	17
B.19(9)	Malignant Neoplasm—prostate	..	..	..	..	..	..	..	..	..	F	2	—	—	—	—	—	—	—	—	—	1	—
B.19(10)	Leukaemia .. ..	..	..	..	..	..	..	..	..	..	M	116	—	—	—	—	—	—	—	—	24	31	41
B.19(11)	Other Malignant Neoplasms ..	..	..	..	..	..	..	..	..	..	F	36	—	—	—	—	—	—	—	—	12	10	6
B.20	Benign and unspecified neoplasms	..	..	..	..	..	..	..	..	..	M	72	—	—	—	—	—	—	—	—	3	20	48
B.21	Diabetes mellitus ..	..	..	..	..	..	..	..	..	..	F	13	—	—	—	—	—	—	—	—	1	4	3
B.22	Avitaminoses, etc.	..	..	..	..	..	..	..	..	..	F	12	—	—	—	—	—	—	—	—	1	4	6
B.46(1)	Other endocrine etc. diseases ..	..	..	..	..	..	..	..	..	..	M	162	—	—	—	—	—	—	—	—	30	58	51
B.23	Anaemias .. ..	..	..	..	..	..	..	..	..	..	F	214	—	—	—	—	—	—	—	—	37	58	85
B.46(2)	Other diseases of blood etc. ..	..	..	..	..	..	..	..	..	..	M	6	—	—	—	—	—	—	—	—	4	—	1
B.46(3)	Mental disorders ..	..	..	..	..	..	..	..	..	..	F	9	—	—	—	—	—	—	—	—	3	2	2
B.24	Meningitis .. ..	..	..	..	..	..	..	..	..	..	M	16	—	—	—	—	—	—	—	—	3	2	11
B.46(4)	Multiple Sclerosis ..	..	..	..	..	..	..	..	..	..	F	34	—	—	—	—	—	—	—	—	1	12	20
B.46(5)	Other diseases of nervous system	..	..	..	..	..	..	..	..	..	M	2	—	—	—	—	—	—	—	—	1	1	—
B.25	Active rheumatic fever ..	..	..	..	..	..	..	..	..	..	F	4	—	—	—	—	—	—	—	—	—	—	—
B.26	Chronic rheumatic heart disease	..	..	..	..	..	..	..	..	..	F	13	—	—	—	—	—	—	—	—	—	—	—
B.27	Hypertensive disease ..	..	..	..	..	..	..	..	..	..	M	8	—	—	—	—	—	—	—	—	—	—	—
B.28	Ischaemic heart disease	..	..	..	..	..	..	..	..	..	F	9	—	—	—	—	—	—	—	—	—	—	—
B.29	Other forms of heart disease ..	..	..	..	..	..	..	..	..	..	M	2	—	—	—	—	—	—	—	—	—	—	—
B.30	Cerebrovascular disease	..	..	..	..	..	..	..	..	..	F	28	—	—	—	—	—	—	—	—	7	6	5
B.46(6)	Other diseases of the circulatory system	..	..	..	..	..	..	..	..	..	M	68	—	—	—	—	—	—	—	—	—	—	—
B.31	Influenza... ..	..	..	..	..	..	..	..	..	..	F	65	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	956	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	760	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	M	161	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	241	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	M	407	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	628	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	M	141	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	186	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	M	76	—	—	—	—	—	—	—	—	—	—	—
		..	..	..	..	..	..	..	..	..	F	62	—	—	—	—	—	—	—	—	—	—	—

B List Number	Causes of Death										Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.32	Pneumonia	..	..	..	..	..	..	..	..	M	216	2	5	—	1	—	—	—	7	16	42	142
B.33(1)	Bronchitis, emphysema	..	..	..	..	..	..	..	..	F	273	2	—	2	—	—	1	2	4	14	44	204
B.33(2)	Asthma	..	..	..	..	..	..	..	..	F	174	—	—	—	—	—	—	—	4	31	65	73
B.46(7)	Other diseases of respiratory system	..	..	..	..	..	..	..	..	M	57	—	—	—	—	—	—	—	2	3	16	36
B.34	Peptic ulcer	..	..	..	..	..	..	..	..	F	6	—	—	—	—	—	—	—	1	1	—	2
B.35	Appendicitis	..	..	..	..	..	..	..	..	F	4	—	—	—	—	—	—	—	1	—	—	1
B.36	Intestinal obstruction and hernia	..	..	..	..	..	..	..	..	M	26	—	2	—	—	—	—	—	4	1	8	12
B.37	Cirrhosis of liver	..	..	..	..	..	..	..	..	F	20	—	—	—	—	—	—	—	1	2	5	11
B.46(8)	Other diseases of digestive system	..	..	..	..	..	..	..	..	M	22	—	—	—	—	—	—	—	—	3	8	11
B.38	Nephritis and nephrosis	..	..	..	..	..	..	..	..	F	20	—	—	—	—	—	—	—	—	2	—	15
B.39	Hyperplasia of prostate	..	..	..	..	..	..	..	..	M	3	—	—	—	—	—	—	—	—	—	—	—
B.49(6)	Other diseases of genito-urinary system	..	..	..	..	..	..	..	..	F	12	—	—	—	—	—	—	—	—	4	10	10
B.40	Abortion	..	..	..	..	..	..	..	..	M	17	—	—	—	—	—	—	—	—	2	8	19
B.41	Other complications of pregnancy etc.	..	..	..	..	..	..	..	..	F	7	—	—	—	—	—	—	—	—	1	4	4
B.46(10)	Diseases of skin subcutaneous tissue	..	..	..	..	..	..	..	..	M	11	—	—	—	—	—	—	—	—	—	5	3
B.46(11)	Diseases of musculo-skeletal system	..	..	..	..	..	..	..	..	F	18	—	—	—	—	—	—	—	—	—	—	—
B.42	Congenital anomalies	..	..	..	..	..	..	..	..	M	11	—	—	—	—	—	—	—	—	—	—	16
B.43	Birth injury, difficult labour etc.	..	..	..	..	..	..	..	..	F	18	—	—	—	—	—	—	—	—	—	2	5
B.44	Other causes of perinatal mortality	..	..	..	..	..	..	..	..	M	11	—	—	—	—	—	—	—	—	—	4	7
B.45	Symptoms and ill-defined conditions	..	..	..	..	..	..	..	..	F	25	—	—	—	—	—	—	—	—	—	—	—
BE.47	Motor vehicle accidents	..	..	..	..	..	..	..	..	M	—	12	6	2	2	—	—	—	—	—	—	—
BE.48	All other accidents	..	..	..	..	..	..	..	..	F	1	7	7	1	1	—	—	—	—	—	—	—
BE.49	Suicide and self-inflicted injuries	..	..	..	..	..	..	..	..	M	22	—	—	—	—	—	—	—	—	—	—	—
BE.50	All other external causes	..	..	..	..	..	..	..	..	F	14	—	—	—	—	—	—	—	—	—	—	—
	Total All Causes	..	..	..	..	..	..	..	..	M	3,347	49	16	6	14	20	16	38	158	525	1,039	1,466
										F	3,416	30	13	6	6	13	15	27	101	303	767	2,152	

Appendix F

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1971

B List Number	Causes of Death		Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.1	Cholera	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.2	Typhoid Fever	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.3	Bacillary dysentry and amoebiasis	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.4	Enteritis and other diarrhoeal diseases	.. ..	F	—	—	—	1	—	—	—	—	—	—	—	—
B.5	Tuberculosis of respiratory system	.. ..	M	2	—	—	—	—	—	—	—	—	—	—	1
B.6(1)	Late effects of respiratory T.B.	.. ..	F	3	—	—	—	—	—	—	—	—	1	—	2
B.6(2)	Other Tuberculosis	.. ..	M	2	—	—	—	—	—	—	1	—	—	1	1
B.7	Plague	.. ..	F	2	—	—	—	—	—	—	—	—	—	—	—
B.8	Diphtheria	.. ..	M	3	—	—	—	—	—	—	—	—	—	—	—
B.9	Whooping Cough	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.10	Streptococcal sore throat and scarlet fever	.. ..	M	1	—	1	—	—	—	—	—	—	—	—	1
B.11	Meningococcal infection	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.12	Acute Poliomyelitis	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.13	Smallpox	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.14	Measles	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.15	Typhus and other rickettsioses	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.16	Malaria	.. ..	M	—	—	—	—	—	—	—	—	—	—	—	—
B.17	Syphillis and its sequelae	.. ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.18	All other infective and parasitic diseases	.. ..	M	1	—	1	—	—	—	1	—	1	2	3	4
B.19(1)	Malignant Neoplasm—buccal cavity etc.	.. ..	F	12	—	—	1	—	—	—	1	—	1	2	6
B.19(2)	Malignant Neoplasm—oesophagus	.. ..	M	11	—	—	—	—	—	—	1	—	1	8	7
B.19(3)	Malignant Neoplasm—stomach	.. ..	F	17	—	—	—	—	—	—	—	1	2	1	2
B.19(4)	Malignant Neoplasm—intestine	.. ..	M	6	—	—	—	—	—	—	—	3	7	13	5
			F	28	—	—	—	—	—	—	—	—	4	4	9
			M	17	—	—	—	—	—	—	—	6	9	25	29
			F	70	—	—	—	—	—	—	1	—	7	14	37
			M	58	—	—	—	—	—	—	—	—	—	40	37
			F	94	—	—	—	—	—	—	2	3	12	32	67
			M	116	—	—	—	—	—	—	1	4	12	32	67

B List Number	Causes of Death	Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.19(5)	Malignant Neoplasm—larynx..	M	6	—	—	—	—	—	—	—	1	—	4	1
B.19(6)	Malignant Neoplasm—lung, bronchus	F	—	—	—	—	—	—	—	—	—	—	—	—
B.19(7)	Malignant Neoplasm—breast..	M	256	—	—	—	—	—	—	—	14	75	107	58
B.19(8)	Malignant Neoplasm—uterus..	F	55	—	—	—	—	—	—	—	7	11	21	15
B.19(9)	Malignant Neoplasm—prostate	M	147	—	—	—	—	1	2	4	21	37	38	2
B.19(10)	Leukaemia ..	F	45	—	—	—	—	—	—	2	7	8	19	44
B.19(11)	Other Malignant Neoplasms ..	M	56	—	—	—	—	—	—	—	2	3	18	9
B.20	Benign and unspecified neoplasms	M	28	—	—	—	3	—	—	—	2	4	4	33
B.21	Diabetes mellitus ..	F	17	—	—	—	—	1	2	7	2	2	6	13
B.22	Avitaminoses etc.	M	165	—	—	—	5	4	2	5	12	36	52	6
B.46(1)	Other endocrine etc. diseases ..	F	215	—	—	1	1	2	2	—	17	47	73	47
B.23	Anaemias ..	M	10	—	—	—	—	—	—	—	1	3	3	2
B.46(2)	Other diseases of blood etc. ..	F	7	—	—	—	—	—	—	—	2	1	4	—
B.46(3)	Mental disorders ..	M	25	—	—	1	—	—	1	1	—	5	10	8
B.24	Meningitis ..	F	38	—	—	—	—	—	—	—	—	4	12	20
B.46(4)	Multiple Sclerosis ..	M	1	—	—	—	—	—	—	—	—	—	—	1
B.46(5)	Other diseases of nervous system	F	3	—	—	—	—	—	—	—	—	2	—	—
B.25	Active rheumatic fever..	M	12	—	—	—	—	—	—	—	—	6	1	8
B.26	Chronic rheumatic heart disease	F	18	—	—	—	—	—	—	—	2	3	4	15
B.27	Hypertensive disease ..	M	14	—	—	—	—	—	—	—	—	—	—	—
B.28	Ischaemic heart disease ..	F	—	—	—	—	—	—	—	—	—	—	—	—
B.29	Other forms of heart disease ..	M	7	—	—	—	—	—	—	—	—	7	14	12
B.30	Cerebrovascular disease	F	20	—	—	—	—	—	—	—	—	—	8	12
B.46(6)	Other diseases of the circulatory system	M	54	—	—	—	—	—	—	—	—	9	22	21
B.31	Influenza..	F	58	—	—	—	—	—	—	—	—	4	12	39
		M	993	—	—	—	—	—	—	—	45	168	384	380
		F	717	—	—	—	—	—	—	—	7	51	159	498
		M	159	—	—	—	1	—	1	1	3	8	33	112
		F	258	—	—	—	—	—	—	—	5	9	40	204
		M	362	—	—	—	—	—	—	—	9	35	103	214
		F	616	—	—	—	—	—	—	—	12	35	127	439
		M	133	—	—	—	—	—	—	—	7	11	47	68
		F	174	—	—	—	—	—	—	—	1	12	36	123
		M	9	—	—	—	—	—	—	—	—	2	4	3
		F	9	—	—	—	—	—	—	—	1	—	2	6

B List Number	Causes of Death	Sex	All Ages	Under 4 weeks	4 weeks and under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75 and over
B.32	Pneumonia	M	182	—	4	—	1	—	—	—	2	9	45	121
B.33(1)	Bronchitis, emphysema	F	212	—	1	1	—	—	—	—	—	16	28	166
B.33(2)	Asthma	M	174	—	—	—	—	2	—	—	5	21	60	86
B.46(7)	Other diseases of respiratory system	F	40	—	—	1	—	—	—	1	—	5	12	23
B.34	Peptic ulcer	M	4	—	—	—	1	1	—	—	—	—	—	—
B.35	Appendicitis	M	4	—	2	—	—	—	—	2	3	—	7	13
B.36	Intestinal obstruction and hernia	F	27	—	1	—	—	—	—	1	1	—	5	15
B.37	Cirrhosis of liver	M	24	—	—	1	—	—	—	—	1	3	8	16
B.46(8)	Other diseases of digestive system	F	28	—	—	—	—	—	—	—	1	3	3	12
B.38	Nephritis and nephrosis	M	18	—	—	—	—	—	—	—	—	—	—	1
B.39	Hyperplasia of prostate	F	1	1	—	—	—	—	—	—	—	—	—	1
B.46(9)	Other diseases of egnito-urinary system	M	2	—	1	—	—	—	—	—	—	—	4	3
B.40	Abortion	F	17	—	—	—	—	1	—	1	—	—	3	11
B.41	Other complications of pregnancy etc.	F	6	—	—	—	—	—	—	—	—	—	—	—
B.46(10)	Diseases of skin subcutaneous tissue	M	7	—	—	—	—	—	—	—	—	—	—	—
B.46(11)	Diseases of musculo-skeletal system	F	22	—	—	—	—	—	—	—	—	—	—	—
B.42	Congenital anomalies	M	52	—	—	—	—	—	—	—	—	—	—	—
B.43	Birth injury, difficult labour etc.	F	22	—	—	—	—	—	—	—	—	—	—	—
B.44	Other causes of perinatal mortality	M	8	—	—	—	—	—	—	—	—	—	—	—
B.45	Symptoms and ill-defined conditions	F	13	—	—	—	—	—	—	—	—	—	—	—
BE.47	Motor vehicle accidents	M	14	12	2	—	1	1	—	1	—	—	—	24
BE.48	All other accidents	F	20	11	5	—	1	1	—	—	—	—	4	72
BE.49	Suicide and self-inflicted injuries	M	21	14	1	—	—	—	—	—	—	—	8	4
BE.50	All other external causes	F	15	5	—	—	—	—	—	—	—	—	5	19
		M	4	3	—	—	—	—	—	—	—	—	11	51
		F	3	—	—	—	—	—	—	—	—	—	3	3
		M	28	—	4	—	—	—	—	—	—	—	—	—
		F	77	—	1	—	—	—	—	—	—	—	—	—
		M	37	—	—	—	—	—	—	—	—	—	—	—
		F	21	—	—	—	—	—	—	—	—	—	—	—
		M	54	—	2	—	4	5	2	4	2	4	9	19
		F	73	—	1	—	2	1	4	1	3	11	11	51
		M	33	—	—	—	—	—	—	—	—	—	5	3
		F	14	—	—	—	—	—	—	—	—	—	4	1
		M	4	—	—	—	—	—	—	—	—	—	—	—
		F	9	—	—	—	—	—	—	—	—	—	—	—
	Total All Causes	M	3,287	31	17	5	21	30	18	51	142	473	1,085	1,414
		F	3,333	19	11	9	9	13	18	31	101	314	733	2,075

Appendix G

In 1965 the Ministry of Health revised the age groupings, hence the changed setting of the table as from that year.

Diphtheria (including combined immunisation)

Year	No. of children who completed a full course of immunisation							Booster
	Under 1	1	2	3	4-7	Others under age 16	Totals	
1970	924	3,241	504	76	169	92	5,006	6,885
1971	731	3,187	554	82	238	117	4,909	6,919

Whooping Cough (including combined immunisation)

The number of children protected against whooping cough is as follows:

Year	Under 1	1	2	3	4-7	Others under age 16	Total	Booster
1970	913	3,182	486 ...	71	75	26	4,753	2,311
1971	731	3,183	527	73	91	23	4,628	1,962

Tetanus (including combined immunisation)

The number of children protected against tetanus is as follows:

Year	Under 1	1	2	3	4-7	Others under age 16	Total	Booster
1970	924	3,241	512	78	184	547	5,486	8,931
1971	731	3,187	560	87	250	495	5,310	8,958

Poliomyelitis

The number of children protected against poliomyelitis is as follows:

Year	Under 1	1	2	3	4-7	Others under age 16	Total	Booster
1970	973	3,136	534	91	225	157	5,116	7,880
1971	731	3,201	491	105	256	138	4,922	8,180

B.C.G. (Anti-Tuberculosis) 1971

No. of Children on Roll	...	...	...	...	...	School Children
						4,549
No. of Children for whom parental consent received	...					4,134
No. tuberculin tested (Heaf tested 2 mm. puncture)	...	...				4,020
No. positive	...	...	...	...	...	272
No. negative	...	...	...	...	...	3,674
No. given freeze-dried B.C.G. vaccine	...	...	...	...	...	3,630

Allocation of Sessions

Appendix H

<i>Dental Treatment</i>						1971	1970	1969
Schools (and Special Schools)	...	...	...	...	...	5,580	5,640	5,558
Pre-School	...	...	...	...	...	245	239	182
Expectant and Nursing Mothers	...	...	...	...	...	8	12	10
Adult Workshops	...	...	...	...	...	39	32	55
Total*	...	...	...	...	...	5,886	5,936	5,824

* This total includes 45 Dental Officer Anaesthetist Sessions in 1970 and 16 in 1971.

<i>Dental Examinations</i>						1971	1970	1969
Schools (and Special Schools)	...	...	...	...	...	698	707	737
Child Health Clinics/Playgroups	...	...	...	...	...	32	40	89
Adult Workshops	...	...	...	...	...	9	8	7
Total	...	...	...	...	...	739	755	833

DENTAL TREATMENT—SCHOOL CHILDREN
(including Special Schools and Junior Training Centres)

						1971				1970	1969
						5-9	10-14	15+	Total	Total	Total
1	Attendances for Treatment (including Orthodontic and Emergency)	...	...	...	...	19,093	19,992	3,369	42,454	42,410	40,449
2	Emergencies	...	...	...	...	435	235	49	719	792	747
3	Number Actually Treated	...	...	...	...	7,981	5,949	1,052	14,982	14,757	13,932
4	Additional Courses of Treatment Commenced	...	...	...	...	1,918	1,392	292	3,602	3,984	3,493
5	Fillings—Permanent Teeth	...	...	...	...	7,087	15,526	3,229	25,842	25,949	27,595
	Deciduous Teeth	...	...	...	...	15,464	909	—	16,373	16,584	15,207
6	Teeth Filled—Permanent Teeth	...	...	...	...	6,118	14,028	3,000	23,146	23,268	24,755
	Deciduous Teeth	...	...	...	...	14,732	883	—	15,615	15,647	14,340
7	Extractions, Carious—										
	—Permanent Teeth	...	...	...	...	169	524	88	781	832	950
	—Deciduous Teeth	...	...	...	...	2,806	1,039	—	3,845	4,601	5,066
8	Extractions, Orthodontic—										
	—Permanent Teeth	...	...	...	...	33	810	86	929	935	763
	—Deciduous Teeth	...	...	...	...	350	352	—	702	581	585
9	No. of General Anaesthetics—										
	—by medical anaesthetists	...	...	...	...	442	244	24	670	655	614
	—by dental officers	...	...	...	...	91	40	1	132	401	578
10	Patients X-Rayed	...	...	...	...	485	965	128	1,578	1,444	1,358
11	Prophylaxis	...	...	...	...	1,973	2,812	702	5,487	5,355	4,971
12	Gum Treatment	...	...	...	...	202	426	173	801	745	536
13	Teeth Otherwise Conserved	...	...	...	...	1,296	81	9	1,386	1,261	1,341
14	Other Operations—										
	—Permanent Teeth	...	...	...	...	530	1,087	275	1,892	1,872	1,660
	—Deciduous Teeth	...	...	...	...	1,819	136	—	1,955	1,493	1,235
15	Teeth Root Filled	...	...	...	...	140	41	14	195	85	62
16	Inlays	...	...	...	...	—	—	2	2	17	5
17	Crowns	...	...	...	...	3	7	8	18	24	10
18	Number of Dentures Fitted	...	...	...	...	3	23	10	36	46	54
19	All Courses of Treatment Completed	...	...	...	...	9,357	6,293	1,175	16,825	16,676	15,732
20	Orthodontics—										
	New Cases Commenced	...	...	...	...				386	394	404
	Cases Completed	...	...	...	...				259	280	229
	Cases Discontinued	...	...	...	...				36	36	41
	No. of Removable Appliances Fitted	...	...	...	...				620	563	495
	No. of Fixed Appliances Fitted	...	...	...	...				14	18	10
	Cases Referred to Hospital Consultant	...	...	...	...				—	24	160
	Orthodontic Attendances	...	...	...	...				7,238	6,664	5,765

DENTAL EXAMINATION—CHILDREN AND ADULTS

Appendix H

		First Examination During Year				Second and Subsequent Examination During Year			
		No. Examined	No. Found to Require Treatment	No. Offered Treatment	No. for Treatment Consented	No. Examined	No. Found to Require Treatment	No. Offered Treatment	No. for Treatment Consented
<i>School Children</i>									
	No. Examined at School	...	...				
	No. Examined at Clinic	...	...				
1971	Total Examined at School and Clinic	54,017	25,466	18,930	10,484	15,202	5,024	4,768	3,105
1970	Total Examined at School and Clinic	4,032	3,303	3,267	3,128	2,928	2,399	2,398	2,395
1969	Total Examined at School and Clinic	58,049	28,769	22,197	13,612	18,130	7,423	7,166	5,500
		55,984	28,184	22,127	13,211	21,009	9,778	8,426	5,722
		58,774	29,332	23,381	13,101	16,079	7,894	6,835	4,526
<i>Pre-School Children</i>									
1971		2,062	923	903	871	555	330	329	328
1970		1,933	892	871	843	514	294	292	292
1969		1,837	677	650	629	471	231	225	224
<i>Expectant and Nursing Mothers</i>									
1971		61	61	61	61	7	7	7	7
1970		62	54	54	54	6	6	6	6
1969		99	74	74	74	6	6	6	6
<i>Adult Workshops</i>									
1971		332	160	121	89	76	41	38	38
1970		339	138	121	99	98	35	35	29
1969		228	103	77	65	121	52	52	40

DENTAL TREATMENT—OTHER CLASSES **Appendix H**

	Pre-School Children			Expectant and Nursing Mothers			Adult Workshops		
	1971	1970	1969	1971	1970	1969	1971	1970	1969
1. Attendances for Treatment (including "Emergency" and "Orthodontic")									
2. Emergencies	1,854	1,745	1,326	171	185	210	295	237	397
3. Number Actually Treated	49	57	58	3	9	6	1	2	6
4. Additional Courses of Treatment Commenced	842	802	592	61	54	71	101	95	94
5. Fillings...	202	173	150	5	6	6	11	10	25
6. Teeth Filled	2,053	1,860	1,496	112	130	125	135	105	223
7. Extractions	1,912	1,733	1,418	105	117	122	125	94	203
8. Number of General Anaesthetics—	285	276	237	30	39	55	44	49	103
—by medical anaesthetists	80	83	46	3	2	2	3	1	2
—by dental officers	16	22	23	—	1	2	—	—	1
9. Patients X-Rayed	22	4	7	21	23	17	14	19	22
10. Prophylaxis	189	174	123	30	26	54	53	26	77
11. Teeth Otherwise Conserved ...	115	142	123	—	—	—	—	—	2
12. Other Operations	290	231	177	36	30	57	12	36	118
13. Teeth Root Filled	5	8	3	—	—	—	—	2	—
14. Inlays and Crowns	—	—	—	—	—	—	—	—	—
15. Number of Dentures Fitted ...	—	—	—	12	3	12	20	17	12
16. All Courses of Treatment Completed	878	850	637	53	27	59	78	68	82

EPIDEMIOLOGY

Incidence and Notification of Infectious Diseases

This table affords a comparison with the preceding five years:

	Number of Corrected Notifications					
	1966	1967	1968	1969	1970	1971
Measles	2,700	5,498	2,506	765	1,736	1,008
Whooping Cough	175	133	170	47	25	103
Diphtheria	—	—	—	1	1	1
Poliomyelitis	—	—	—	—	—	—
Scarlet Fever	140	131	72	64	44	74
*Erysipelas	14	11	11	—	—	—
*Pneumonia	129	90	75	—	—	—
Meningitis	3	7	5	2	1	7
Tuberculosis	122	73	62	51	48	49
Typhoid or Paratyphoid	—	2	1	—	—	1
Dysentery	109	174	90	108	5	9
Food Poisoning	48	6	13	87	24	11
Ophthalmia Neonatorum	8	—	—	—	—	—
*Puerperal Pyrexia	6	—	1	—	—	—
Smallpox	—	—	—	—	—	—
Acute Encephalitis	—	—	—	1	1	1
Anthrax	—	—	—	—	—	—
†Infective Jaundice	—	—	56	73	115	96
‡Yellow Fever	—	—	—	—	—	—
‡Tetanus	—	—	—	—	—	—
Leptospirosis	—	—	—	—	—	2
Leprosy	—	—	—	—	—	—
Cholera	—	—	—	—	—	—
Plague	—	—	—	—	—	—
Relapsing Fever	—	—	—	—	—	—
Typhus	—	—	—	—	—	—
Malaria	—	—	—	—	1	2

* Not notifiable with effect from 1.10.68.
† Notifiable with effect from 1.4.68.
‡ Notifiable with effect from 1.10.68.

For the 11th year in succession, no cases of poliomyelitis were notified in Devon and this is considered to be mainly due to the successful vaccination campaign.

Venereal Diseases

	New Cases Treated					
	1966	1967	1968	1969	1970	1971
Syphilis	15	12	3	9	13	14
Gonorrhoea	104	164	102	101	110	190
Other conditions	447	512	325	411	458	583

Venereal diseases are not notifiable and the figures shown above are only in respect of cases treated at the special centres. It is obvious that these figures are an unknown fraction of the total cases of venereal disease occurring in the area.

TUBERCULOSIS 1970

This year 43 cases were notified, a fall over last year of 3.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1970	1969	1968	1967	1966
Under 5	—	1	—	—	—	1	1	4	2	2	4
5-14	—	2	—	—	—	2	2	—	2	1	6
15-24	3	4	—	—	3	4	7	5	6	5	17
25-34	2	2	1	—	3	2	5	5	3	8	13
35-44	—	2	—	1	—	3	3	2	10	11	14
45-54	3	—	—	—	3	—	3	10	8	11	26
55-64	4	1	1	—	5	1	6	10	14	8	20
65+	6	3	3	4	9	7	16	15	17	7	22
Unknown	—	—	—	—	—	—	—	—	—	—	—
Totals	18	15	5	5	23	20	43	51	62	73	122
	33		10		43						

TUBERCULOSIS 1971

This year 49 cases were notified, an increase over last year of 6.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1971	1970	1969	1968	1967
Under 5	—	1	—	—	—	1	1	1	4	2	2
5-14	2	—	—	1	2	1	3	2	—	2	1
15-24	2	3	—	—	2	3	5	7	5	6	5
25-34	—	—	1	1	1	1	2	5	5	3	8
35-44	2	2	—	1	2	3	5	3	2	10	11
45-54	3	4	1	2	4	6	10	3	10	8	11
55-64	2	1	2	—	4	1	5	6	10	14	8
65+	5	5	2	6	7	11	18	16	15	17	27
Unknown	—	—	—	—	—	—	—	—	—	—	—
Totals	16	16	6	11	22	27	49	43	51	62	73
	32		17		49						

TUBERCULOSIS

Deaths from Tuberculosis, 1970

Classification	Age Groups																Total		Grand Total	
	0-		1-		5-		15-		25-		45-		65-		75-					
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F				
Respiratory ...	—	—	—	—	—	—	—	—	—	—	—	2	1	3	—	3	—	8	1	9
Non-Respiratory ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Totals ...	—	—	—	—	—	—	—	—	—	—	—	2	2	3	—	3	—	8	2	10

The deaths in this group were seven less than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication. It should be noted that 60% of deaths occurred in persons over 65.

TUBERCULOSIS

Deaths from Tuberculosis, 1971

Classification	Age Groups																Grand Total		
	0-		1-		5-		15-		25-		45-		65-		75-			Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		M	F
Respiratory ...	—	—	—	—	—	—	—	—	1	—	2	—	1	1	1	1	5	2	7
Non-Respiratory ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
Totals ...	—	—	—	—	—	—	—	—	1	—	2	—	1	1	2	5	3	8	8

The deaths in this group were two less than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication. It should be noted that 62½% of deaths occurred in persons over 65.

Appendix J

Treatment—Chest Clinics. The work of the four chest clinics for the year 1970 is summarised in the table below:

	Barnstaple	Exeter	Plymouth	Torquay	Total
Patients on Register 1.1.70 ...	174	405	34	63	676
New Notifications:					
(a) respiratory	7	15	15	12	49
(b) non-respiratory	2	5	—	2	9
Deaths	1	10	5	6	22
Patients on Register 31.12.70 ...	172	406	53	127	758
First examination of suspects ...	255	949	442	257	1,903
Cases of T.B. found	5	10	11	11	37
Cases of positive sputum	3	29	4	9	45
Contacts examined	44	109	20	133	306
Cases of T.B. found in contacts ...	—	2	—	—	2
Contacts vaccinated with B.C.G.	29	64	11	25	129

Treatment—Chest Clinics. The work of the four chest clinics for the year 1971 is summarised in the table below:

	Barnstaple	Exeter	Plymouth	Torquay	Total
Patients on Register 1.1.71 ...	172	406	53	127	758
New Notifications:					
(a) respiratory	8	16	2	13	39
(b) non-respiratory	3	8	2	4	17
Deaths	4	8	2	2	16
Patients on Register 31.12.71 ...	171	396	46	116	729
First examination of suspects ...	125	940	134	377	1,576
Cases of T.B. found	5	11	4	14	34
Cases of positive sputum	2	21	—	11	34
Contacts examined	50	65	7	111	233
Cases of T.B. found in contacts ...	—	1	—	3	4
Contacts vaccinated with B.C.G.	35	64	9	31	139

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